MDS DEMOGRAPHIC/MED HISTORY FORM

FULL LEGAL NAME_____
Last name First name MI Nickname

MAILING ADDRESS_____

HOME PHONE # _____WORK/MOBILE_____

EMAIL _____ ☐ check here for apt. reminder via email

DATE OF BIRTH _____SSN # _____ ☐ Male ☐ Female

Occupation _____ Employer_____

Emergency contact: name _____ phone _____

MEDICAL HISTORY (mark all that you have had or currently have) ☐ NONE

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone marrow transplant
- ☐ BPH (enlarged prostate
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ COPD (lung disease)
- ☐ Coronary artery disease
- ☐ Diabetes
- ☐ ESRD (kidney failure)
- ☐ GERD (GI reflux)
- ☐ Heart attack
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV/ AIDS
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Seizures
- ☐ Radiation treatment
- ☐ Other _____

FAMILY MEDICAL HISTORY

Mother_____Father_____

Sibling_____Other_____

SURGICAL HISTORY (mark all that you have had) ☐ NONE

- ☐ Cancer surgery _____
- ☐ Heart procedure _____
- ☐ Orthopedic surgery _____
- ☐ Transplant _____
- ☐ Other _____

DERMATOLOGIC HISTORY (mark all that you have had or currently have) ☐ NONE

- ☐ actinic keratosis
- ☐ basal cell skin cancer
- ☐ squamous cell skin cancer
- ☐ melanoma
- ☐ other skin disorder _____
- ☐ abnormal/precancerous moles
- ☐ family member w skin cancer
  who? _____type? _____
- ☐ other skin diseases in your family _____

MEDICATIONS_____ ☐ NONE

_____

_____

ALLERGIES_____ Type of reaction_____ ☐ NONE

CURRENT OR PAST SMOKER? _____CONSUME ALCOHOL_____ AMOUNT AND FREQUENCY?_____

ADVERSE REACTION TO DENTAL ANESTHESIA/GENERAL ANESTHESIA? ☐ YES ☐ NO

_____ _____

Patient Signature Doctor Signature