6TH SENSE MEDICAL HISTORY

Patient Name (PRINT) _____

Date of Birth_____ Age_____ Weight_____(lbs) Height_____

1. Have you been hospitalized or under the care of a medical doctor during the past two years? Reason?

   _____

2. **List medications** taken the past two years and reason:

   _____

   _____

3. List **allergy** (i.e., itching, rash, swelling, vomiting) to latex, penicillin, aspirin, or any other medication:

   _____

4. **CIRCLE** any of the following you have or have had:

Birth Defects/Syndrome	Inherited Condition	Rash/Hives/Eczema/Skin Problem
Heart Failure	Heart Disease or Attack	Heart Surgery/Stent
Angina Pectoris (Chest Pain)	High/Low Blood Pressure	Glaucoma
Heart Murmur	Rheumatic Fever/Heart Disease	Transfusion/Receiving Blood Product
Congenital Heart Defect	Artificial Heart Valve	Impaired Vision/Hearing/Speech
Pacemaker	Stroke/Aneurysm	Bacterial Endocarditis
Anemia/Bruise Easily	MRSA(methicillin resistant staph)	Stomach Ulcers/Gastroesophageal Reflux
Hemophilia	Tuberculosis (TB)	Nervous/Anxiety Disorder
Sickle Cell Disease	Sarcoidosis	Psychiatric Treatment
Emphysema	Asthma/Airway Disease	Artificial Joint
Sinus Problems	Epilepsy/Seizures	Steroid Therapy
Fainting/Dizzy Spells	Diabetes Type 1 / 2	Hypo/Hyperglycemia
Thyroid/Pituitary Disease	Allergies –Food, Metal, Etc.	Arthritis/Scoliosis/Joint Problem
Cancer Type: _____	Tumor	Rheumatism
Chemotherapy/Radiation Treatment	Organ Transplant	Hepatitis/Jaundice/Liver Disease
Cystic Fibrosis	Current or Previous Tobacco Use	Vaping
Bladder/Kidney Disease	Recreational Drug Use/Addiction	Alcoholism
Sexually Transmitted Disease	AIDS Related/HIV	

5. Ever been victim of abuse or neglect (physical, emotional, psychological, sexual)? _____
6. Ever had a reaction to or problem with an anesthetic? _____
7. Do you ever have to stop because of **pain in your chest, or shortness of breath**, or because you are very tired? Yes or no?
8. Do your ankles swell during the day? Yes or No?
10. Lost/gained more than 10lbs in last year? Yes or No? Eating disorder? Yes or No?
11. Wake up from sleep due to short of breath/snoring? Yes or No?
12. Are you on a special diet? Yes or No?
13. Any significant medical history not listed above that the dentist should be told?

    _____

14. **Women**: Pregnant? Yes or No? Is there a possibility you are pregnant? Yes or No?
    Nursing? Yes or No? Birth Control? Yes or No?

To the best of my knowledge all of the preceding answers are true and correct. I will notify my provider at next visit if there has been any change.

_____ _____

Date Signature of Patient or Guardian