

MDS DEMOGRAPHIC/MED HISTORY FORM

Nickname: _____

FULL LEGAL NAME _____

First name

MI

Last name

Date of Birth

Age

MAILING ADDRESS _____

PRIMARY PHONE NUMBER _____ HOME WORK MOBILE

SECONDARY PHONE NUMBER _____ HOME WORK MOBILE

MALE FEMALE SSN # _____ EMAIL _____

Emergency contact: Name _____ Phone _____

Guarantor (Under 18) _____ Relationship to Patient _____

How did you hear about us? _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> ESRD (kidney failure) | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD (GI reflux) | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Gout | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Bone marrow transplant | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> BPH (enlarged prostate) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> COPD (lung disease) | <input type="checkbox"/> Hypertension | |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Hyperthyroidism | |
| <input type="checkbox"/> History of recurrent infections, MRSA, or Staph? | | |

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

- | | |
|--|---|
| <input type="checkbox"/> actinic keratosis | <input type="checkbox"/> abnormal/precancerous moles |
| <input type="checkbox"/> basal cell skin cancer | <input type="checkbox"/> family member w skin cancer |
| <input type="checkbox"/> squamous cell skin cancer | who? _____ type? _____ |
| <input type="checkbox"/> melanoma | <input type="checkbox"/> other skin diseases in your family _____ |
| <input type="checkbox"/> other skin disorder _____ | |

SURGICAL HISTORY (mark all that you have had) NONE

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

MEDICATIONS _____ NONE

ALLERGIES _____ Type of reaction _____ NONE

ADDITIONAL INFORMATION

CURRENT OR PAST SMOKER? _____ CONSUME ALCOHOL _____ AMOUNT AND FREQUENCY? _____

ADVERSE REACTION TO DENTAL ANESTHESIA/GENERAL ANESTHESIA? YES NO

HAVE YOU HAD THE FOLLOWING VACCINES THIS YEAR? FLU: Y OR N PNEUMONIA: Y OR N

DO YOU HAVE AN ADVANCED DIRECTIVE? Y OR N

OCCUPATION _____ EMPLOYER _____

FAMILY MEDICAL HISTORY (please list immediate family health history)

Mother _____ Father _____

Sibling _____ Other _____

Patient Signature

Date

Doctor Signature

Revised 3/2018