Dr. Tim Kirkpatrick

Family & Cosmetic Dental Office

11040 W. Bluemound Rd, Suite 201
Wauwatosa, WI 53226
(414) 476-4777

MEDICAL HISTORY

Patient's Name _____ **Date of Birth** _____ **Male** ☐ **Female** ☐

Last First Initial

PUT A CHECKMARK NEXT TO THE APPROPRIATE ANSWER IF YOU DON'T KNOW THE CORRECT ANSWER. PLEASE WRITE OR TYPE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

	YES	NO
1. Physician's Name _____ Address: _____ Phone: _____		
2. Are you under a physician's care? _____ Since when? _____ Why? _____	☐	☐
3. When was your last complete physical exam? _____	☐	☐
4. Are you taking any medication or substances? _____ If yes, please list medications in comments section or bring on separate sheet.	☐	☐
5. Do you routinely take health related substances? (Vitamins, herbal supplements)	☐	☐
6. Are you allergic to any medications or substances? (please list in comments)	☐	☐
7. Do you have any other allergies or hives? _____	☐	☐
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? _____	☐	☐
9. Are you sensitive to any metals or latex? _____	☐	☐
10. Are you pregnant or suspect you may be? _____	☐	☐
11. Do you use any birth control medications? _____	☐	☐
12. Have you ever been treated for or been told you might have heart disease? _____	☐	☐
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? _____	☐	☐
14. Have you ever had rheumatic fever? _____	☐	☐
15. Are you aware of any heart murmurs? _____	☐	☐
16. Do you have high or low blood pressure? _____	☐	☐
17. Have you ever had a serious illness or major surgery? _____ If so, explain _____	☐	☐
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? _____	☐	☐
19. Have you ever taken Fosamax, Zometa, Aredia, or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? _____	☐	☐
20. Do you have inflammatory disease, such as arthritis or rheumatism? _____	☐	☐
21. Do you have artificial joints/prosthesis? _____	☐	☐
22. Do you have any blood disorders, such as anemia, leukemia, etc? _____	☐	☐
23. Have you ever bled excessively after being cut or injured? _____	☐	☐
24. Do you have any stomach problems? _____	☐	☐
25. Do you have any kidney problems? _____	☐	☐
26. Do you have any liver problems? _____	☐	☐
27. Are you diabetic? _____	☐	☐
28. Do you have fainting or dizzy spells? _____	☐	☐
29. Do you have asthma? _____	☐	☐
30. Do you have epilepsy or seizure disorders? _____	☐	☐
31. Do you or have had venereal or any sexually transmitted disease? _____	☐	☐
32. Have you tested HIV positive? _____	☐	☐
33. Do you have AIDS? _____	☐	☐
34. Have you had or do you test positive for hepatitis? _____	☐	☐
35. Do you or have you had T.B.? _____	☐	☐
36. Do you smoke, chew, use snuff or any other forms of tobacco? _____	☐	☐
37. Do you regularly consume more than one or two alcoholic beverages a day? _____	☐	☐
38. Do you habitually use controlled substances? _____	☐	☐
39. Have you had psychiatric treatment? _____	☐	☐
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?	☐	☐
41. Do you have any disease condition, or problem not listed? If so, explain in comments.	☐	☐
42. Is there anything else we should know about your health that we have not covered in this form? _____	☐	☐
43. Would you like to speak to the Doctor about any problem? _____	☐	☐

COMMENTS AREA

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ **DATE** _____

DENTIST'S SIGNATURE _____ **DATE** _____