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Medical History

Today's date: _____

Patient name: _____

Brief history of the problem or concern: _____

Have you seen another physician about this problem? Yes ____ No ____

If yes, who? _____

Medications taken routinely, both prescription and non-prescription, including aspirin, birth control pills, etc. _____

Have you ever used diet pills? Yes ____ No ____

Allergies: _____

Have you ever had a bad reaction to any medication? Yes ____ No ____

If yes, please list the medications: _____

Have you ever been told that you should take an antibiotic before undergoing dental or surgical procedures?

Yes ____ No ____ Which one(s)? _____

Do you have any prosthetic (artificial) devices implanted (i.e. heart valve, hip, knee)?

Yes ____ No ____

If yes, please list devices: _____

Do you have a pacemaker? Yes ____ No ____

Have you every been told that you should not or cannot donate blood?

Yes_____ No_____ If yes, why? _____

Do you smoke now? _____ # packs per day: _____

Do you drink now? _____ # per day: _____

List previous operations, including cosmetic surgery and serious injuries:

Medical History: Have you ever had or been treated for:

- None of the conditions listed below
- HIV
- AIDS or AIDS related complex
- Hepatitis
- Diabetes
- Heart attack
- Heart trouble
- Tumors, benign or malignant (cancer)
- Low blood count, anemia, bleeding
- Bleeding tendency
- Mental or emotional problems
- Breathing problems, shortness of breath
- Asthma
- Urinary tract or kidney disease
- Fractures, scoliosis, back trouble
- Endocrine or thyroid disease
- High blood pressure
- Congenital heart disease
- Stroke
- Arthritis
- Migraine
- Eye or ear problems
- Leukemia
- Neurologic disease or epilepsy
- Gastrointestinal problems, colitis, ulcer
- Psychiatric history (please specify) _____
- Other (please specify) _____