

JOSEPH M. CROW, D.M.D., P.C.

4634 Bit & Spur Road

Mobile, AL 36608

Patient Medical History

Patient's Name: _____ Date: _____

Please indicate if you have the following conditions:

<input type="checkbox"/> ABNORMAL BLEEDING	<input type="checkbox"/> FAINTING SPELLS	<input type="checkbox"/> RADIATION THERAPY
<input type="checkbox"/> ALCOHOL ABUSE	<input type="checkbox"/> FEVER BLISTERS	<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> FREQUENT HEADACHES	<input type="checkbox"/> SEIZURES
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> SHINGLES
<input type="checkbox"/> ANGINA PECTORIS	<input type="checkbox"/> HAY FEVER	<input type="checkbox"/> SICKLE CELL DISEASE
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> SINUS PROBLEMS
<input type="checkbox"/> ARTIFICIAL JOIN/BONE	<input type="checkbox"/> HEART SURGERY	<input type="checkbox"/> STROKE
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEMOPHILIA	<input type="checkbox"/> THYROID PROBLEMS
<input type="checkbox"/> BLOOD TRANSFUSION	<input type="checkbox"/> HEPATITIS A	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> CANCER	<input type="checkbox"/> HEPATITIS B	<input type="checkbox"/> ULCERS
<input type="checkbox"/> COLITIS	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> VENEREAL DISEASE
<input type="checkbox"/> CONGENITAL HEART DEFECT	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> YELLOW JAUNDICE
<input type="checkbox"/> COSMETIC SURGERY	<input type="checkbox"/> KIDNEY PROBLEMS	<u>ALLERGIES</u>
<input type="checkbox"/> DIABETES	<input type="checkbox"/> LIVER DISEASE	<input type="checkbox"/> ASPIRIN
<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> CODEINE
<input type="checkbox"/> DRUG ABUSE	<input type="checkbox"/> MITRAL VALVE PROLAPSE	<input type="checkbox"/> DENTAL ANESTHETICS
<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> PACE MAKER	<input type="checkbox"/> ERYTHROMYCIN
<input type="checkbox"/> EPILEPSY	<input type="checkbox"/> PNEUMOCYSTITIS	<input type="checkbox"/> PENICILLIN
	<input type="checkbox"/> PSYCHIATRIC PROBLEMS	<input type="checkbox"/> LATEX
		<input type="checkbox"/> METALS

Please list any other allergies or conditions not listed above: -

Primary Care Physician: _____

Are you nursing or Pregnant? (How many weeks?) _____

Do you smoke? _____ **Height:** _____ **Weight:** _____

Please list any medications:

Signature: _____

Date: _____

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