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:

☐ ABNORMAL BLEEDING	☐ FAINTING SPELLS	☐ RADIATION THERAPY
☐ ALCOHOL ABUSE	☐ FEVER BLISTERS	☐ RHEUMATIC FEVER
☐ ALLERGIES	☐ FREQUEST HEADACHES	☐ SEIZURES
☐ ANEMIA	☐ GLAUCOMA	☐ SHINGLES
☐ ANGINA PECTORIS	☐ HAY FEVER	☐ SICKLE CELL DISEASE
☐ ARTHRITIS	☐ HEART ATTACK	☐ SINUS PROBLEMS
☐ ARTIFICIAL JOIN/BONE	☐ HEART SURGERY	☐ STROKE
☐ ASTHMA	☐ HEMOPHILIA	☐ THYROID PROBLEMS
☐ BLOOD TRANSFUSION	☐ HEPATITIS A	☐ TURBERCULOSIS
☐ CANCER	☐ HEPATITIS B	☐ ULCERS
☐ COLITIS	☐ HIGH BLOOD PRESSURE	☐ VENEREAL DISEASE
☐ CONGENITAL HEART DE-FECT	☐ HIV/AIDS	☐ YELLOW JAUNDICE
	☐ KIDNEY PROBLEMS	
☐ COSMETIC SURGERY	☐ LIVER DISEASE	**ALLERGIES**
☐ DIABETES	☐ LOW BLOOD PRESSURE	☐ ASPIRIN
☐ DIFFICULTY BREATHING	☐ MITRAL VALVE PROLAPSE	☐ CODEINE
☐ DRUG ABUSE	☐ PACE MAKER	☐ DENTAL ANESTHETICS
☐ EMPHYSEMA	☐ PNEUMOCYSTITIS	☐ ERYTHROMYCIN
☐ EPILEPSY	☐ PSYCHIATRIC PROBLEMS	☐ PENICILLIN
		☐ LATEX
		☐ 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:** _____