CRAIG W. JACKSON, DDS, PA
MEDICAL HISTORY FORM

Patient's Name _____ Date of Birth __/__/__ M F

Primary Care Physician's Name _____ Phone _____
Address _____

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

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE
PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE __/__/__