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MEDICAL HISTORY

Please Circle Appropriate Response:

NO YES Are you considered a healthy person?
NO YES Are you now taking any drugs or medications?
Which ones? _____

NO YES Are you allergic to any medications?
Which ones? _____

Family Doctor: _____
Address: _____

NO YES Would you object to our office contacting your family doctor in regard to any medical problem that may arise?

NO YES Have you ever received local anesthesia (Novocaine or Xylocaine) by a dentist or doctor?

NO YES Have you ever received general anesthesia?

NO YES Have you ever had any bad reaction to either local or general anesthesia?
Please describe _____

NO YES Do you take blood thinners?
Which ones? _____

NO YES Do you take vitamins regularly?
Which ones? _____

NO YES Do you take vitamins containing Vitamin E?

NO YES Do you take aspirin products or anti-inflammatory medicines or headache medicines?
Which ones? _____

NO YES Do you exercise regularly?

NO YES Are you pregnant?

DO ANY FAMILY MEMBERS HAVE: (Circle if yes)

Heart trouble	Tuberculosis
Excessive scarring	High blood pressure
Diabetes	Psychiatric or "nerve" problems
Asthma	Thyroid problems
Excessive bruising	Excessive bleeding tendency
Bad reactions to anesthesia	

HAVE YOU HAD:

NO YES Heart trouble
NO YES Blood pressure or related problems
NO YES Liver problems, gallbladder problems, or "yellow Jaundice"
NO YES

Circle which one

NO YES Kidney disease
NO YES Diabetes
NO YES Stomach problems, indigestion or ulcers
NO YES Bleeding tendency or excessive bruising
NO YES Any part of your body paralyzed or numb
NO YES Psychiatric consultation
NO YES Epilepsy-convulsions or seizures
NO YES Broken bones of the face, neck, jaw or back
NO YES Back trouble
NO YES Abnormal chest x-rays
NO YES Abnormal Electrocardiogram (ECG)
NO YES Asthma or other respiratory problems
NO YES Any medical treatment for nervous condition
NO YES Excessive scarring
NO YES Tuberculosis
NO YES Thyroid problems
NO YES Any other illnesses. If so please list:
NO YES Fluctuations of more than 15 pounds in your body weight.
NO YES Abdominal or inguinal hernia
NO YES History of blood clots in legs or lungs
NO YES History of legs swelling

PLEASE LIST ALL PRVIOUS SURGERIES AND DATES:

DO YOU:

NO YES Wear contact lenses
NO YES Have dentures, false teeth, caps or bridges
NO YES Smoke? How much? _____
NO YES Drink alcohol? How much? _____
NO YES Think you are pregnant? Date of last menstrual period _____
NO YES Have any contagious or infectious conditions?
NO YES Have you been exposed directly or indirectly to any one with HIV (AIDS)

The above information is strictly confidential

Witness Signature

Date

Patient Signature

Date

Patient Printed Name