Medical History

Kathleen A. Varley, D.D.S.
James J. Varley, D.D.S.

Name _____ Date ____/____/____

Address _____ DOB ____/____/____

_____ SS# ____-____-____

Preferred Phone # (____) ____-____ Please circle: HOME WORK MOBILE

Alternate Phone # (____) ____-____ Please circle: HOME WORK MOBILE

Alternate Phone # (____) ____-____ Please circle: HOME WORK MOBILE

List **ALLERGIES** to food and/or medicine

_____

_____

_____

Are you currently, or have you been under the care of a **medical doctor** in the past **two years?** _____ ☐ yes ☐ no

Date of last medical check-up: _____

Please (CIRCLE) any health condition you have had or have at present:

Smoking or Tobacco Use	Heart Condition	Diabetes	Cancer
Emphysema	Valve Replacement	Thyroid Disorder	Radiation Therapy
Chronic Cough	Heart Pacemaker	Bone Disease/Osteoporosis	Chemotherapy
Tuberculosis	Rheumatic Fever	Hormone Replacement	Immunosuppressive Disorder
Sinus Problems	Chest Pain	Liver Disease/Hepatitis	Epilepsy/Seizures
Hip/Knee Replacement	Stroke	Kidney Disease	Neurological Disorder
Arthritis/Reumatism	Abnormal Bleeding	Glaucoma	Psychiatric Care
Ulcers	High/Low Blood Pressure	Steroid Medication	Cold Sores

Other Condition Not Listed _____

_____

_____

For Women Only:

Are you taking birth control pills? ☐ Are you pregnant? ☐ How many months? ____ Are you nursing? ☐

PLEASE CONTINUE TO THE NEXT PAGE

Medical History Updated Date ____/____/____ Signature _____ Hyg. _____

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Medical History

Physician's Name _____

Physician's Phone # ( ) - _____ Physician's Location _____

Please list any **medications** you are currently taking or have taken in the **past 6 months**:

Drug Name	Reason Taking	Date Started	Taking Currently? If no, Date Stopped	Staff Initial

Please describe any medical condition that you currently have or have had in the past:

Patient Signature _____ Date __/__/__