Bhupendra R. Patel MDSC
9663 Franklin Avenue
Franklin Park, IL 60131
Phone: 847-455-4750
Web: www.PatelMedicalEsthetics.com
or www.PatelFamilyDentist.com

Medical History

Name _____ SS# _____ Telephone _____

Address _____

Date of Birth _____ Age _____ Sex ❑ M ❑ F Date _____

Please answer the following questions, if answer is yes to any, please explain below.

Do you have or have had:

1.	Any previous surgery	Yes ❑	No ❑	If yes, explain _____
2.	Been hospitalized for any reason	Yes ❑	No ❑	If yes, explain _____
3.	Anemia or other blood condition	Yes ❑	No ❑	If yes, explain _____
4.	Heart disease	Yes ❑	No ❑	If yes, explain _____
5.	Irregular or rapid heartbeat	Yes ❑	No ❑	If yes, explain _____
6.	Chest pain or abnormal EKG	Yes ❑	No ❑	If yes, explain _____
7.	Shortness of breath after mild exercise	Yes ❑	No ❑	If yes, explain _____
8.	High blood pressure	Yes ❑	No ❑	If yes, explain _____
9.	Disease of the lung or Chronic lung condition (TB, Asthma, Emphysema, Pneumonia, Bronchitis)	Yes ❑	No ❑	If yes, explain _____
10.	Persistent cough or coughed up blood	Yes ❑	No ❑	If yes, explain _____
11.	Frequent or severe sore throats or colds	Yes ❑	No ❑	If yes, explain _____
12.	Stroke	Yes ❑	No ❑	If yes, explain _____
13.	Dizzy spells or fainting	Yes ❑	No ❑	If yes, explain _____
14.	Frequent or severe headaches	Yes ❑	No ❑	If yes, explain _____
15.	Epilepsy or seizures	Yes ❑	No ❑	If yes, explain _____
16.	Head injury or knocked unconscious	Yes ❑	No ❑	If yes, explain _____
17.	Leg Cramps, varicose veins or swelling of ankles or feet	Yes ❑	No ❑	If yes, explain _____
18.	Kidney or bladder trouble	Yes ❑	No ❑	If yes, explain _____
19.	Stomach trouble (Ulcers or indigestion)	Yes ❑	No ❑	If yes, explain _____
20.	Gallbladder trouble (Gallstones)	Yes ❑	No ❑	If yes, explain _____
21.	Liver disease or jaundice	Yes ❑	No ❑	If yes, explain _____
22.	Rectal trouble	Yes ❑	No ❑	If yes, explain _____
23.	Hernia or any rupture	Yes ❑	No ❑	If yes, explain _____
24.	Severe ear trouble or difficulty in hearing	Yes ❑	No ❑	If yes, explain _____
25.	Difficulty with your vision (Blurred, Glaucoma, Cataracts, etc.)	Yes ❑	No ❑	If yes, explain _____
26.	Broken bones or bone disease	Yes ❑	No ❑	If yes, explain _____
27.	Prostate problem	Yes ❑	No ❑	If yes, explain _____
28.	Disease, swelling, limitation or pain in joints	Yes ❑	No ❑	If yes, explain _____
29.	Muscle weakness or paralysis	Yes ❑	No ❑	If yes, explain _____

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30. Neck pain or whiplash injury — Yes ❑ No ❑ If yes, explain _____
31. Back pain or back injury — Yes ❑ No ❑ If yes, explain _____
32. Arthritis, gout or rheumatism — Yes ❑ No ❑ If yes, explain _____
33. Skin rash from soaps or chemicals etc. — Yes ❑ No ❑ If yes, explain _____
34. Allergies (plants, foods, dusts, chemicals, pollen, medications, latex, etc.) — Yes ❑ No ❑ If yes, explain _____
35. Growth, tumor or Cancer — Yes ❑ No ❑ If yes, explain _____
36. Venereal disease (Syphilis, Gonorrhea, etc.) — Yes ❑ No ❑ If yes, explain _____
37. Treated for any mental illness — Yes ❑ No ❑ If yes, explain _____
38. Have you been treated for drug or alcohol abuse — Yes ❑ No ❑ If yes, explain _____
39. Excessive worry, depression or nervousness — Yes ❑ No ❑ If yes, explain _____
40. Recent weight gain or loss of more than 10 pounds — Yes ❑ No ❑ If yes, explain _____
41. Do you have any problem with your uterus, vagina, ovaries or been treated for any female problem — Yes ❑ No ❑ If yes, explain _____
42. Do you have painful or irregular menstruation — Yes ❑ No ❑ If yes, explain _____
43. Workers compensation disability — Yes ❑ No ❑ If yes, explain _____
44. Problem sleeping — Yes ❑ No ❑ If yes, explain _____
45. Have you used or used (marijuana, cocaine, heroin or other recreational drugs) — Yes ❑ No ❑ If yes, explain _____
46. Do you drink Alcohol? — Yes ❑ No ❑ If yes, how often? _____
47. Do you smoke? — Yes ❑ No ❑ If yes, how much and what? _____
48. Are you a regular used of sleeping pills, painkillers or tranquilizers? — Yes ❑ No ❑ If yes, explain _____
49. Do you take any medication regularly? — Yes ❑ No ❑ If yes, explain _____
50. Any illness not mentioned above — Yes ❑ No ❑ If yes, explain _____

_____ _____
Patient's signature (guardian if minor) Date