Medical History
Cape Cod Community College

First Name_____ **Last Name**_____

Date of Birth_____ Sex: M___ F____

Phone Numbers: Home _____Business_____
Street Address: _____
Town_____State_____Zip_____

Mailing Address: _____
Town_____State_____Zip_____

Dentist: _____Phone:_____
Address: _____
_____
Are you current having dental pain or concerns? _____
If yes describe: _____

Primary Doctor
_____Phone:_____
Address_____

Person to notify in case of an emergency: _____Phone _____

Medical History **Circle one**
Are you currently seeing a doctor for a current medical condition? No Yes
If yes, doctor‘s name
_____Phone:_____
Address_____
Reason_____

Date of last physical_____ **Date of last blood pressure**_____

Date of last Hepatitis B vaccine and /or titer_____
Current Medications _____ _____
_____ _____

Today’s Blood Pressure…….____/_____

Do you have or have you had any of the following: **Circle one**

Cancer	No	Yes
Rheumatic Fever	No	Yes
High Blood Pressure	No	Yes
Heart Disorder	No	Yes
Stroke	No	Yes
Bleeding Tendency	No	Yes
Blood Disorder	No	Yes
Diabetes	No	Yes
Hepatitis	No	Yes
Liver Disease	No	Yes
Kidney Disease	No	Yes
Epilepsy	No	Yes
Respiratory Disease	No	Yes
Hay fever	No	Yes
Asthma	No	Yes
Venereal Disease	No	Yes
AIDS	No	Yes
Drug Allergies	No	Yes
Penicillin	No	Yes
Sulfur	No	Yes
Erythromycin	No	Yes
Local Anesthetics	No	Yes
Other:_____		
Radiation Exposure	No	Yes
Emotional Problems	No	Yes
Pregnant	No	Yes
Prosthetic Joint or valve replacement	No	Yes
Herpes	No	Yes
Tuberculosis	No	Yes

I affirm that the above health history is accurate and give my consent to CCCC to contact my physician or dentist regarding any health condition the needs to be verified.

Signature_____ Date _____