Medical History

Name: ____ DOB:____________

Conditions: Please check only the problems that apply to you

___ Abnormal/excessive bleeding
___ AIDS or HIV infection
___ Alzheimer's/dementia
___ Anemia
___ Angina
___ Anxiety
___ Arteriosclerosis
___ Arthritis/Gout
___ Aspirin Therapy
___ Asthma
___ Autoimmune disease
___ Back problems
___ Breathing problems/respiratory disease
___ Bruises Easily
___ Cancer/chemotherapy/radiation treatment
___ Cardiovascular disease
___ Chest pain upon exertion
___ Chronic pain
___ Cold Sores/Fever Blisters
___ Congestive heart failure
___ COPD
___ Damaged heart valves
___ Diabetes
___ Emphysema
___ Epilepsy
___ Fainting spells or seizures
___ Fibromyalgia
___ Frequent headaches
___ Gastrointestinal disease
___ G.E. Reflux/persistent
___ Glaucoma
___ Hearing difficulties
___ Heart attack
___ Heart Conditions
___ Heart Defibrillator
___ Heart Murmur
___ Heart Stents
___ Heart Surgery
___ Heart Valve Replacement
___ Hepatitis
___ High blood pressure
___ HPV (Human Papilloma Virus)
___ Hypoglycemia
___ Jaw Joint Pain
___ Joint Replacement
___ Kidney Disease
___ Kidney problems
___ Low blood pressure
___ Low pain tolerance
___ Malnutrition
___ Mitral valve prolapse
___ Multiple Sclerosis
___ Nervousness/Depression
___ Neurological disorders
___ Pacemaker
___ Pain Contract
___ Persistent swollen glands in neck
___ Pregnant
___ Pressure on upper lip causes
___ tooth - related problems
___ Rheumatoid arthritis
___ Severe headaches/migraines
___ Sexually transmitted infection (STI)
___ Shingles
___ Sinus trouble
___ Sleep Apnea
___ Spina Bifida
___ Stroke
___ Thyroid problems
___ TMJ Disorder
___ Tuberculosis
___ Tumors or growths
___ Ulcers
___ Wheelchair Access
___ Other
____

Do you have any disease, condition or problem that is not listed that you think I should know about?

____

Are you allergic or have you reacted adversely to any of the following?

___ Aspirin ___ Percodan ___ Tetracycline ___ Penicillin
___ Davron ___ Latex ___ Codeine ___ Sulfa
___ Nitrous Oxide ___ Local Anesthetic ___ Erythromycin ___Vallum
___ Acrylic ___ Metal ___Other ________________________

Please elaborate on any reactions you have to the indicated allergies:

____

Date of last physical exam: _______________________

Are you taking birth control or hormone replacement? _____ (yes or no)

Are you nursing? ______ (yes or no)

Do you smoke or use chewing tobacco? ____

What medications are you currently taking?

____

____

____

Are you under a physician's care? _______ What is it for?____

Please list any major surgeries or head/neck injuries you have had:

____

____

____

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment.

By signing below you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

____ ________________

Signature *Date*