MEDICAL HEALTH HISTORY

The confidential information provided is important to your dental health

Patient Name: ____

Do you have any of the following?
(Please check any that apply)

- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Asthma
- ☐ Cancer – Chemotherapy
- ☐ Chest Pains
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Glaucoma
- ☐ HIV – AIDS
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Hepatitis A
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve
- ☐ Pace Maker
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Alzheimers
- ☐ Heart Stent
- ☐ Blood Clots
- ☐ Allergic to Penicillin
- ☐ Allergic to Codeine
- ☐ Allergic to Advil
- ☐ Celiac Disease
- ☐ Cerebral Palsy
- ☐ Titanium Plate
- ☐ Lupus
- ☐ A-Fib
- ☐ Blood Transfusion

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

- ☐ Latex materials
- ☐ Penicillin or other antibiotics
- ☐ Local anesthetics (“Novacain”)
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Other: ____________________________

Women:

- ☐ May be Pregnant, expected delivery date:________________________
- ☐ Taking hormones or contraceptives

Do you smoke or use chewing tobacco? (Circle one)

Yes No

Are you taking any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Antibiotics or sulfa drugs
- ☐ High blood Pressure medicine
- ☐ Antidepressants or tranquilizers
- ☐ Insulin, Orinase, or other diabetes drug
- ☐ Nitroglycerin
- ☐ Cortisone or other steroids
- ☐ Osteoporosis (bone density) medicine
- ☐ Other: ________________________

Name of your physician:
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Do you have any disease, condition or problems not listed above? ______________________________

Signature of patient or parent____________________________________

Date: ____________________________