

Medical Health History

Patient Name _____

Check All That Apply

Heart Conditions:

- Chest Pain
- Shortness of Breath
- High/Low Blood Pressure
- Heart Murmur
- Heart valve problems
- Mitral Valve Prolapse
- Heart Attack
- By-Pass Surgery
- Is premedication required by physician?

Blood Conditions:

- Easy bruising
- Frequent nosebleeds
- Abnormal bleeding
- Blood disease (anemia)
- Ever require blood transfusion?

Allergy Conditions:

- Hay Fever
- Sinus problems
- Skin rashes
- Taking allergy medication?
- Asthma

Intestinal Conditions:

- Ulcers
- Special diet
- Weight gain or loss
- Kidney/Bladder problems
- Acid Reflux
- Eating disorders

Bone or Joint Conditions:

- Arthritis
- Back or neck pain
- Joint replacement (hip, knee, implants)
Date of replacement _____
- Is premedication required by physician?

History of head injury:

- Fainting spells
- Seizures
- Stroke
- Epilepsy
- Other neurological disease
- Frequent or severe headaches

Are you allergic to any of the following?

- Latex or rubber dam
- Local anesthetics
- Penicillin
- Sulfa drugs
- Barbiturates, sedatives or sleeping pills
- Aspirin, Acetaminophen, or Ibuprofen
- Codeine, Demerol or other narcotic
- Reaction to metal

Cancer/Tumor:

If so, when? _____
Type _____

Diabetes:

- Urinate more than 6X per day
- Thirsty or dry mouth often
- Family history of diabetes

Other Conditions:

- Thyroid Problems
- Fibromyalgia
- Chronic fatigue syndrome
- Tuberculosis
- Other respiratory disease?
- Do you drink alcohol?
If so, how much? _____
- Do you use tobacco products?
If so, which type and how often, how long?

- History of drug or alcohol abuse
- Hepatitis, jaundice or liver trouble
- Herpes or STD's
- HIV positive/AIDS
- ARC Syndrome
- Do you have Glaucoma?
- Do you wear contact lenses?

Do you have any other disease or medical condition not listed above? _____

In the past 12 months have you taken any of the following:

- Antibiotics or sulfa drugs
- Anticoagulants (Coumadin)
- High Blood pressure medication
- Antidepressants/tranquilizers
- Insulin, Orinase or similar drug
- Aspirin/NSAID
- Digitalis or drugs for heart problems
- Nitroglycerin
- Cortisone (steroids)
- Dilantin/seizure medication

Women Only:

- Are you taking contraceptives?
- Are you pregnant?
- Are you taking hormones?
- Are you nursing?
- Have you reached menopause?

Please list any medications, supplements or vitamins you are currently taking.

IF THERE ARE ANY CHANGES IN MY MEDICAL HISTORY, I WILL NOTIFY THE DENTIST.

Patient's Signature

Date

Dr. Signature