

MEDICAL HEALTH HISTORY

Patient's name: _____ Birth date: _____

If minor, parents names: _____

Do you have or have you had any of the following?

(Please check any that apply)

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Thyroid disorders
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Acid reflux/ Heartburn
- Asthma
- Temporomandibular joint disease

Do you smoke or use chewing tobacco? yes no

If yes, how often? _____

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

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: _____

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: _____

Women:

- May be pregnant
Expected delivery date: _____
- Taking hormones or contraceptives

Name of your physician: _____ Physician's phone number: _____

Do you have any disease, condition, or problem not listed above? _____

Have you ever had an adverse reaction to dental treatment? _____

Are you apprehensive of dental treatment/ interested in sedation? _____

Please add anything else you would like us to know about: _____

Signature of patient (or parent) _____ Date _____