

MEDICAL HEALTH HISTORY

Confidential

Patient Name: _____ Today's Date: _____ Birthdate: _____

Medical Doctor's Name: _____ Year of Last Medical Visit: _____

Have you had any serious illness or operations this year? If yes, please list: _____

Has your health significantly changed in the past year? If yes, please explain: _____

Women: Are you pregnant? Yes No Are you nursing? Yes No Taking birth control pills? Yes No

Check if you have or have ever had any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, type: _____ | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes, type: _____ | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints, type: _____ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer, type: _____ | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemical Dependency
(including Alcoholism) | <input type="checkbox"/> Hepatitis, type: _____ | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |

MEDICATIONS

List medications you are currently taking:

Pharmacy Name: _____

Pharmacy Phone Number: _____

ALLERGIES

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Local Anesthesia |

Other allergy not listed: _____

DOCTOR'S NOTES:

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child ever has a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date