



## Medical Health History

Do you have a Medical Doctor?  Yes  No

Medical Doctor's Name \_\_\_\_\_

City \_\_\_\_\_

Date of Last Physical \_\_\_\_\_

Please mark either **Yes** or **No** to indicate if you currently have or have ever had any of the following:

<input type="checkbox"/> <input type="checkbox"/> Heart Problems	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Kidney Problems	<input type="checkbox"/> <input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> <input type="checkbox"/> Chronic Sinus
<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> <input type="checkbox"/> Nervous Problems	<input type="checkbox"/> <input type="checkbox"/> Chronic Ear Problems
<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Tonsils Removed	<input type="checkbox"/> <input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Phen-Fen/Redux
<input type="checkbox"/> <input type="checkbox"/> Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Malignancies	<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease/Herpes
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Radiation Treatment(s)	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> H.T.L.V.
<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> <input type="checkbox"/> H.I.V.
<input type="checkbox"/> <input type="checkbox"/> Prosthetic Joint(s)	<input type="checkbox"/> <input type="checkbox"/> Hepatitis _____	<input type="checkbox"/> <input type="checkbox"/> Cancer _____	<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> A.I.D.S.

If **yes**, year joint replaced: \_\_\_\_\_

**Other illnesses or conditions** - Please list all other current or past significant illnesses or conditions (*include date of onset*):

\_\_\_\_\_  
\_\_\_\_\_

**Medications** - Please list medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

**Allergies** - Causing swelling, rash, hives, itching, or difficulty breathing:

Please mark either **Yes** or **No** to indicate if you currently have or have ever had any allergic reaction to the following:

<input type="checkbox"/> <input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> <input type="checkbox"/> Latex	<input type="checkbox"/> <input type="checkbox"/> Penicillin	<input type="checkbox"/> <input type="checkbox"/> Codeine	<input type="checkbox"/> <input type="checkbox"/> Aspirin	<input type="checkbox"/> <input type="checkbox"/> Sulfa	<input type="checkbox"/> <input type="checkbox"/> Iodine
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**Other Allergies:** \_\_\_\_\_

**(Women Only)** Are you pregnant?  Yes  No If **Yes**, How many months? \_\_\_\_\_

## Dental Health History

Name of Previous Dentist \_\_\_\_\_

City \_\_\_\_\_

Date of Last Visit \_\_\_\_\_

Date of last dental X-Rays \_\_\_\_\_

Please mark either **Yes** or **No** to indicate if you currently have any of the following:

<input type="checkbox"/> <input type="checkbox"/> Sensitive teeth	<input type="checkbox"/> <input type="checkbox"/> Sores or growths in your mouth	<input type="checkbox"/> <input type="checkbox"/> Clicking or sore jaw	<input type="checkbox"/> <input type="checkbox"/> Are you happy with the color of your teeth?
<input type="checkbox"/> <input type="checkbox"/> Bleeding or sore gums	<input type="checkbox"/> <input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> <input type="checkbox"/> Braces	<input type="checkbox"/> <input type="checkbox"/> Are you happy with your smile?

Other Dental Problems: \_\_\_\_\_

If Patient is a child, is this their first visit to a Dentist?  Yes  No

Are you aware of any dental problems that your child may have: \_\_\_\_\_

### For All Patients

I hereby state that I have answered all of the above questions truthfully and have given all information concerning my health and medical history.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

**For Office Use Only:**

\_\_\_\_\_