

MEDICAL HISTORY

Patient Name: _____ **Date:** _____

BP _____

Are you under a physician's care now? O Yes O No. If yes, explain:

Are you taking any medications, over-the-counter pills? O Yes O No. If yes, list:

Do you use tobacco? O Yes O No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Metal Latex Local Anesthetics

Other _____

Please check any of the following you have had or currently have:

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Lung Disease/
Pneumonia |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Artificial Heart Valve | Spells/Dizziness | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Artificial | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Pain in Jaw Joints |
| Joint/Prosthesis | <input type="checkbox"/> Frequent Headache | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Rheumatic Fever/
Rheumatic Heart |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | Disease |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stomach/Intestinal
Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital Heart | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disease |
| Problems | <input type="checkbox"/> High/low Blood
Pressure | <input type="checkbox"/> Other medical |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Kidney Problems | |
| <input type="checkbox"/> Cosmetic Procedures | <input type="checkbox"/> Leukemia | |
| <input type="checkbox"/> Diabetes | | |

Have you ever had gum treatments or periodontal therapy? Yes/No

When was your last dental treatment? _____ What was it for? _____

When was your last hygiene appointment? _____

Please list your **physicians, specialists, and locations** below.

Drs. Name _____ Specialty _____

City: _____ Phone: _____

Drs. Name _____ Specialty _____

City: _____ Phone: _____

Signature: _____

*** All information is confidential and will not be released without your permission.**