MEDICAL HEALTH HISTORY

ATTENTION

General health (please check): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Name and address of physician _____

Phone: _____ Date of last complete physical? _____

Are you taking any medication now? Yes ☐ No ☐ For what purpose? _____

Please list: _____

_____

HAVE YOU EVER BEEN TREATED FOR:

Heart disease or heart attack . . . . . Yes ☐ No ☐
Rheumatic fever . . . . . Yes ☐ No ☐
High blood pressure . . . . . Yes ☐ No ☐
Ulcers . . . . . Yes ☐ No ☐
Tuberculosis or lung disease . . . . . Yes ☐ No ☐
Diabetes . . . . . Yes ☐ No ☐
Epilepsy . . . . . Yes ☐ No ☐
Anemia (Sickle Cell) . . . . . Yes ☐ No ☐
Congenital heart lesions . . . . . Yes ☐ No ☐
Cancer . . . . . Yes ☐ No ☐
Pacemaker . . . . . Yes ☐ No ☐
Artificial valve implant . . . . . Yes ☐ No ☐
Artificial joints prothesis . . . . . Yes ☐ No ☐

Mitral Valve Prolapse . . . . . Yes ☐ No ☐
Major operation . . . . . Yes ☐ No ☐
Heart murmer . . . . . Yes ☐ No ☐
Kidney disease . . . . . Yes ☐ No ☐
Asthma or hay fever . . . . . Yes ☐ No ☐
Thyroid disease . . . . . Yes ☐ No ☐
Hepatitis . . . . . Yes ☐ No ☐
Arthritis . . . . . Yes ☐ No ☐
Stroke . . . . . Yes ☐ No ☐
Glaucoma . . . . . Yes ☐ No ☐
Blood disease or disorders such as:
Anemia . . . . . Yes ☐ No ☐
Leukemia . . . . . Yes ☐ No ☐
Venereal disease . . . . . Yes ☐ No ☐
HIV . . . . . Yes ☐ No ☐

Have you ever been treated (other than diagnostic) with X-ray? . . . . . Yes ☐ No ☐

Are you allergic to: Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other medications ☐ _____

Are you subject to prolonged bleeding? Yes ☐ No ☐ When you are cut do you heal quickly . . . . . Yes ☐ No ☐

Are you subject to fainting spells? . . . . . Yes ☐ No ☐

(WOMEN) Are you pregnant . . . . . Yes ☐ No ☐ How long? _____

Do you have any problem that would prevent you from receiving dental care now? . . . . . Yes ☐ No ☐

I CERTIFY THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient Signature _____

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