Medical Health History

Have you ever had any of the following medical issues? Please check those that apply.

☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Acid Reflux
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Drug Abuse
☐ Dry Mouth
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting/Dizziness
☐ Heart Attack/Stroke
☐ Heart disease
☐ Heart Murmur
☐ Hepatitis
☐ Herpes/Fever Blisters/HPV
☐ High Blood Pressure
☐ HIV/AIDS
☐ Kidney disease
☐ Liver Disease
☐ Mental Disorders
☐ Nerve Disorders
☐ Pacemaker
☐ Radiation/Chemotherapy
☐ Pregnancy/Trying due date_____
☐ Tuberculosis
☐ Tumors
☐ History of Fosamax (history of bisphoshonate)

List of Surgeries: _____

List any medications you are currently taking: _____

_____

Do you have any Allergies: _____

Do you take Aspirin daily? Yes ☐ No ☐ Are you taking a blood thinner? Yes ☐ No ☐

Are you under medical treatment at this time? Yes ☐ No ☐
Name of Physician _____ Phone: _____

Dental Health History

Have you had any of the following dental issues? Please check those that apply:
☐ Bleeding gums ☐ teeth grinding/clenching ☐ Mouth ulcers
☐ Sinus problems ☐ TMJ Disorder ☐ Reaction to local anesthetic

Reason for today's visit _____ Approx. date of last dental visit/cleaning _____

Do you chew tobacco? Yes ☐ No ☐ Smoke? Yes ☐ No ☐

To the best of my knowledge all of the preceding answers and information provided and true and correct. If I ever have a change in my health, it is my responsibility to inform the doctors at the next appointment.

_____
_____
Please Print Name

_____
_____
Signature of patient, parent or guardian Date