MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Head/neck radiation related to cancer or tumor
- ❑ Heart ailment or angina (heart attack)
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis/liver disease or alcoholism
- ❑ Periodontal "gum" disease
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Mood disorder
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Problems with dental anesthetic ("getting numb")

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you aware, or has anyone told you, that you grind your teeth at night? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely, to any of the following?

- ❑ Latex materials
- ❑ Penicillin
- ❑ Other antibiotic NAME_____
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Metformin or other diabetes-related drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids including prednisone
- ❑ Bisphosphonates or other osteoporosis (bone density) medicine
- ❑ LIST MEDICATIONS (Copies of your existing list can be made)

_____

_____

_____

Women:

- ❑ Pregnant/may be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician (if applicable):

_____

Do you have any disease, condition, or problem not listed above?

_____

_____

Please add anything else you would like us to know about:

_____

_____

Printed name of patient (or parent) _____ Date of birth _____

Signature of patient (or parent) _____ Date _____

Our office is HIPAA compliant and committed to meeting and exceeding the standards of infection control mandated by OSHA and the CDC.