MEDICAL HEALTH HISTORY
Confidential

Patient Name: _____ Today's Date: _____ Birthdate: _____

Medical Doctor's Name: _____ Year of Last Medical Visit: _____

Have you had any serious illness or operations this year? If yes, please list: _____

Has your health significantly changed in the past year? If yes, please explain: _____

Women: Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check if you have or have ever had any of the following:

☐ Anemia	☐ Circulatory Problems	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis, type: _____	☐ Cortisone Treatments	☐ HIV/AIDS	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Diabetes, type: _____	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Joints, type: _____	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Glaucoma	☐ Liver Disease	☐ Swelling of Feet/Ankles
☐ Back Problems	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Blood Disease	☐ Heart Problems	☐ Pacemaker	☐ Tuberculosis
☐ Cancer, type: _____	☐ Hemophilia	☐ Respiratory Disease	☐ Ulcer
☐ Chemical Dependency (including Alchoholism)	☐ Hepatitis, type: _____	☐ Rheumatic Fever	☐ Other _____

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacy Name: _____

Pharmacy Phone Number: _____

ALLERGIES

☐ Aspirin	☐ Penicillin
☐ Sulfa drugs	☐ Codeine
☐ Latex	☐ Local Anesthesia

Other allergy not listed:

DOCTOR'S NOTES:

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child ever has a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date