MEDICAL HISTORY

Date:	Patient Name:	Birth Date:

HEALTH HISTORY

Physician's Name:	Phone:	Date of Last Visit:

Please check (✓) if you have or have had problems with any of the following:			
☐ Yes ☐ No	Anxiety	☐ Yes ☐ No	Heart Problems
☐ Yes ☐ No	AIDS/HIV	☐ Yes ☐ No	Hepatitis Type _____
☐ Yes ☐ No	Anemia	☐ Yes ☐ No	High Blood Pressure
☐ Yes ☐ No	Arthritis, Rheumatism	☐ Yes ☐ No	Jaw Pain
☐ Yes ☐ No	Artificial Heart Valve	☐ Yes ☐ No	Kidney Disease
☐ Yes ☐ No	Artificial Joints	☐ Yes ☐ No	Liver Disease
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Low Blood Pressure
☐ Yes ☐ No	Bleeding Abnormality	☐ Yes ☐ No	Mitral Valve Prolapse
☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No	Pacemaker
☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Psychiatric Care
☐ Yes ☐ No	Chemical Dependency	☐ Yes ☐ No	Radiation Treatment
☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No	Respiratory Disease
☐ Yes ☐ No	Circulatory Problems	☐ Yes ☐ No	Rheumatic Fever
☐ Yes ☐ No	Cough, persistent or bloody	☐ Yes ☐ No	Shortness of Breath
☐ Yes ☐ No	Diabetes A1C Level _____	☐ Yes ☐ No	Sinus Trouble
☐ Yes ☐ No	Depression	☐ Yes ☐ No	Skin Rash
☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Thyroid Problems
☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Tonsillitis
☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Tuberculosis
☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Ulcer
☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Weight loss, unexplained
Any other medical problems not listed above?		☐ Yes ☐ No	Oral Cancer
☐ Yes ☐ No	Women: Are you pregnant?	☐ Yes ☐ No	Women: Taking birth control?
☐ Yes ☐ No	Surgeries?	If so, name of medication:	
☐ Yes ☐ No	Do you require an antibiotic pre-medication for your dental appointments?		
☐ Yes ☐ No	Have you had any changes in your health during the last 12 months?		

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

ALLERGIES

List any allergies: