MEDICAL HISTORY

NAME: ____

ADDRESS: ____

PHONE (Home): ____________ (Cell): ____________ EMAIL ADDRESS: ____________________

WHAT KIND OF REMINDERS DO YOU PREFER? TEXT – EMAIL – PHONE

CURRENT OCCUPATION: ______________________________

Please check any of the following conditions that apply to you:

- ☐ ADD / ADHD
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Back Pain
- ☐ Bleeding Gums
- ☐ Cancer: ____________
- ☐ Clotting Disorder
- ☐ Depression
- ☐ Diabetes
- ☐ Dry Mouth
- ☐ Drug Addiction
- ☐ Eating Disorders
- ☐ Fainting
- ☐ Heart Conditions
- ☐ Heart Surgery
- ☐ Hepatitis B / C
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV Positive/AIDS
- ☐ Jaw Pain
- ☐ Joint Replacement: ____________
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorder
- ☐ Pacemaker
- ☐ Pregnant
- ☐ Radiation History
- ☐ Seizures
- ☐ Sinus Disorders
- ☐ Sleep Apnea
- ☐ Stomach Disorders
- ☐ Stroke
- ☐ Teeth Clenching
- ☐ Teeth Grinding
- ☐ Tooth Pain
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Other: ____________ ____________________

Do you have any of the following allergies?

Medication:	Reason:
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________

- ☐ Aspirin
- ☐ Codeine
- ☐ Hydrocodone
- ☐ Ibuprofen
- ☐ Latex

Patient Signature (Guardian, if child): ______________________________ Date: ____________

Dentist Signature: ______________________________

MEDICAL HISTORY

NAME: ____

ADDRESS: ____

PHONE (Home): _____________ (Cell): _____________ EMAIL ADDRESS: _______________________________

WHAT KIND OF REMINDERS DO YOU PREFER? TEXT – EMAIL – PHONE

CURRENT OCCUPATION: ____

- ☐ Nitrous Oxide
- ☐ Penicillins
- ☐ Sulfa
- ☐ Triazolam
- ☐ Valium
- ☐ Other _____________ ___________________

Do you smoke or chew tobacco? _______________

How much? _____________ For how long? ________

Patient Signature (Guardian, if child): ____Date: _____________________

Dentist Signature: ____