JohnWHITEDDS
Master of Academy of General Dentistry • Fellow of Academy of Dentistry International

INSTRUCTIONS: *If hand writing, please fill out in **black** pen ink only.*

Medical Health History

Name of Physician or place you receive medical care:

Telephone No.: ( )

Has there been any change in your health in the last year?

☐ Yes ☐ No ☐ Don't know

If yes, please explain:

Do you currently have a "Do Not Resuscitate" (DNR) order in effect?

☐ Yes ☐ No ☐ Don't know

Is it possible that you could be pregnant at this time? *(For females only)*

☐ Yes ☐ No ☐ Don't know

Medications

Are you currently taking any medications? (Include prescription medicines, birth control pills, and over-the-counter medicines such as aspirin, vitamins, or herbal supplements)

☐ Yes ☐ No

If yes, please list medication, dose, when, and how often you take each:

Allergies

Are you allergic to, or have you had a reaction to any medications or other substances including latex?

☐ Yes ☐ No ☐ Don't know

If yes, list each, **and** describe what happened when you took it:

Are there any medications that make you sick or nauseated?

☐ Yes ☐ No ☐ Don't know

If yes, list each, **and** describe what happened when you took it:

Have you ever had or been treated by a physician for any of the following?

☐ Severe or frequent headaches ☐ Sinus problems ☐ Emotional problems

Have you ever had or been treated by a physician for any of the following *(continued)* ?

☐ Seizure or epilepsy	☐ Hearing disorders	☐ Neurological problems/numbness
☐ Eye disorder	☐ Glaucoma	☐ Stroke or mini-stroke
☐ Emphysema/COPD	☐ Asthma	☐ Positive test for TB/tuberculosis
☐ Damaged heart valves	☐ Artificial heart valve	☐ Heart surgery
☐ Heart defect at birth	☐ Heart murmur	☐ Pacemaker
☐ High blood pressure	☐ Low blood pressure	☐ Angina (chest pain)
☐ Heart Attack	☐ Shortness of breath with normal activity	
☐ Frequent swelling of ankles	☐ Blood transfusion	☐ Prolonged bleeding from a cut
☐ Hemophilia	☐ Refusal for blood donation	☐ Thyroid disorder
☐ Artificial organ	☐ Artificial joint	☐ Hepatitis/Jaundice
☐ Other liver disorder	☐ HIV positive status	☐ Stomach ulcer
☐ Unexplained weight gain/loss	☐ Arthritis	☐ Intestinal diseases
☐ Kidney disorder	☐ Dialysis	☐ Diabetes
☐ Skin disorder	☐ Tumors or growths	☐ Cancer
☐ Chemotherapy	☐ Radiation treatment	☐ Genetic disorder

Please describe any other health problems, not previously mentioned, that you would like to make us aware of:

Risk Factors

(Understand that all information is strictly confidential and will be used only as it relates to your oral health care.)

Have you at any time used any of the following tobacco products? If yes, please indicate when last used.

Chewing tobacco	☐ Never used	Last used: _____
Snuff	☐ Never used	Last used: _____
Pipe	☐ Never used	Last used: _____
Cigars	☐ Never used	Last used: _____

How many packs of cigarettes do you smoke per day?

☐ None ☐ <1 pack/day ☐ 1 – 2 packs/day ☐ 2 – 3 packs/day ☐ 3+ packs/day

How many drinks of beer, wine or liquor do you drink per day?

☐ None ☐ <1/day ☐ 1 – 2/day ☐ 3 – 5/day ☐ 6+/day

Have you ever had or been treated by a physician for any of the following?

☐ Alcohol dependence ☐ Addiction to "pain killers" or opioids

Have you at any time used any of the following? If yes, please indicate when last used.

Cocaine	☐ Never used	Last used: _____
Methamphetamine	☐ Never used	Last used: _____

I hereby acknowledge that I have answered these questions accurately and truthfully to the best of my knowledge. I agree to report any new medications I am taking, as well as any other changes in my health to this practice at the earliest possible time.

Signature of patient, or parent, or guardian (responsible party): _____

Print Name: _____ Relationship to the patient: _____ Date: _____/_____/_____