JohnWHITEDDS

Fellow of Academy of General Dentistry • Fellow of Academy of Dentistry International

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 so, please explain:

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, 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
☐ Seizure or epilepsy
☐ Emotional problems
☐ Eye disorder
☐ Hearing disorders
☐ Asthma
☐ Sinus problems
☐ Neurological problems/numbness
☐ Stroke
☐ Glaucoma
☐ Emphysema/COPD
☐ Positive test for TB/tuberculosis

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

- ☐ Damaged heart valves
- ☐ Shortness of breath with normal activity
- ☐ Artificial heart valve
- ☐ Heart murmur
- ☐ Heart defect at birth
- ☐ Heart surgery
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Angina (chest pain)
- ☐ Pacemaker
- ☐ Frequent swelling of ankles
- ☐ Sickle-cell disease
- ☐ Prolonged bleeding from a cut
- ☐ Hemophilia
- ☐ Blood transfusion
- ☐ Thyroid disorder
- ☐ Refusal for blood donation
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Other liver disorder
- ☐ Stomach ulcer
- ☐ HIV positive status
- ☐ Intestinal diseases
- ☐ Kidney disorder
- ☐ Dialysis
- ☐ Arthritis
- ☐ Diabetes
- ☐ Artificial organ
- ☐ Artificial joint
- ☐ Unexplained weight gain/loss
- ☐ Skin disorder
- ☐ Tumors or growths
- ☐ Genetic disorder/chromosomal disorder
- ☐ Chemotherapy
- ☐ Cancer
- ☐ Radiation treatment

Risk Factors

Do you now use, or have you at any time used any of the following?

☐ None ☐ Marijuana ☐ Cocaine ☐ Methamphetamine

How many packs of cigarettes do you smoke per day?

☐ None ☐ Less than 1 pack ☐ 1 – 2 packs ☐ 2 – 3 packs ☐ 3 or more packs

Do you use now, or have you at any time used any of the following tobacco products?

☐ None ☐ Chewing tobacco ☐ Snuff ☐ Pipe ☐ Cigars

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

☐ None ☐ Less than 1 ☐ 1 – 2 ☐ 3 – 5 ☐ 6 or more

Other

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

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

I 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, or any 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:____/____/____