JohnWHITEDDS

Master 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 yes, 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	☐ Sinus problems	☐ Emotional problems
☐ 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

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

☐ High blood pressure	☐ Low blood pressure	☐ Angina (chest pain)
☐ Heart Attack	☐ Shortness of breath with normal activity	
☐ Frequent swelling of ankles	☐ Sickle-cell disease	☐ 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
☐ Intestinal diseases	☐ Kidney disorder	☐ Dialysis
☐ Arthritis	☐ Diabetes	☐ Skin disorder
☐ Tumors or growths	☐ Cancer	☐ Chemotherapy
☐ Radiation treatment	☐ Genetic disorder or chromosomal abnormality	

Risk Factors

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: _____

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

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

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 hereby acknowledge that I have answered these questions accurately and truthfully to the best of my knowledge. I understand that all information is strictly confidential and will be used only as it relates to my care. I agree to report any new medications I am taking, as well as 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: _____/_____/_____