Medical health history

FOR OFFICE USE ONLY
Reviewed By: ____________
Date: ________________

Patient Name: ____________________________ **Birth date:** ______________________

Home #: ☐ ______________________ **Work #:** ☐ _____________________ **Cell #:** ☐ _____________________

Address: ____
Street / Apt# City State Zip Code

E-Mail Address: ☐ ____

Answer the following questions as completely and accurately as possible. All information is CONFIDENTIAL. Please circle "yes" or "no" to all questions, and write in your answers as appropriate.

1. **A.** Are you under the care of a physician at this time or within the past six months? **YES** **NO**
   If yes, for what condition? ____

   B. Have you been hospitalized or had any surgeries/procedures within the past 12 months? **YES** **NO**
   If yes, please explain? ____

2. Are you allergic to any medicines, drugs, latex or other substances? **YES** **NO**
   If so, please specify: ____

3. Have you ever taken appetite suppressant drugs such as Phen-Fen? **YES** **NO**
   If so, please list: ____

4. Are you happy with your smile? **YES** **NO**
   If not, what would you change? ____

5. Do you have or have you had any of the following diseases/problems? **PLEASE CHECK YES OR NO**

		YES	NO			YES	NO
A.	Abnormal bleeding	☐	☐	**M.**	High blood pressure	☐	☐
B.	Asthma	☐	☐	**N.**	Diabetes (list type)	☐	☐
C.	Heart disease	☐	☐	**O.**	Active tuberculosis	☐	☐
D.	Damaged/replaced heart valves	☐	☐	**P.**	Kidney/renal disease	☐	☐
E.	Heart attack	☐	☐	**Q.**	Hepatitis/jaundice (list type)	☐	☐
F.	Heart murmur/inborn heart defects	☐	☐	**R.**	Epilepsy/seizures	☐	☐
G.	Angina	☐	☐	**S.**	Joint replacement	☐	☐
H.	Infective endocarditis	☐	☐	**T.**	Stroke	☐	☐
I.	Mitral valve prolapse	☐	☐	**U.**	Thyroid problems	☐	☐
J.	Unshielded pacemaker	☐	☐	**V.**	Cancer/chemotherapy/radiation	☐	☐
K.	HIV/AIDS or other STDs	☐	☐	**W.**	High cholesterol	☐	☐
L.	Rheumatic heart disease	☐	☐	**X.**	Bleeding gums/chronic bad breath	☐	☐

Please explain any YES answers:
____
____
____

6. Do you have any disease, condition, or problem not listed above that would pose a significant risk to the health or safety of yourself or others during performance of dental procedures? If so, please explain:
____

7. Please list any **premedication, medications, pills, or drugs** which you are currently taking - both prescription and nonprescription - especially **anything you have consumed within the last 24 hours**. (*There are some drugs that may interact with local anesthetics and can put you at risk.)*
____
____
____

WOMEN ONLY: Are you pregnant? **YES** **NO** If yes, what is the expected due date? ______________

I certify that I have read and understand the above. I acknowledge that I have answered these questions accurately and completely. I will not hold Dr.'s Porter/Holder responsible for any action taken or not taken because of errors I may have made when completing this form.

PATIENT SIGNATURE: ____**DATE:** __________________
(parent/guardian signature if under 18)