Submit By Email

MEDICAL HISTORY

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know
Heart attack When?	☐	☐	☐
Angina / chest pain	☐	☐	☐
Coronary artery disease	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Congenital heart defects	☐	☐	☐
Damaged heart valves	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Artificial heart valves	☐	☐	☐
Pacemaker / defibrillator/stents	☐	☐	☐
Heart murmur	☐	☐	☐
Other Heart Condition	☐	☐	☐
Bruise easily	☐	☐	☐
Abnormal / prolonged bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion. If yes, date:	☐	☐	☐
Hemophilia	☐	☐	☐
Stroke	☐	☐	☐
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Arthritis	☐	☐	☐
Joint pain	☐	☐	☐
Chronic pain	☐	☐	☐
Cancer / chemotherapy / radiation treatment or medication	☐	☐	☐
Disease, drug, or radiation-induced immunosuppression	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Diabetes--Type I (use insulin) or Type II	☐	☐	☐
Kidney problems	☐	☐	☐

	Yes	No	Don't Know
AIDS or HIV infection	☐	☐	☐
Hepatitis Type:_____ Date contracted:	☐	☐	☐
Jaundice	☐	☐	☐
Liver Disease	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. reflux / persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells	☐	☐	☐
Seizures	☐	☐	☐
Thyroid problems	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Eating disorder anorexia__ bulimia__	☐	☐	☐
Mental health disorders	☐	☐	☐
ADHD/ADD (Attention Deficit)	☐	☐	☐
Anxiety	☐	☐	☐
Sleep Disorder	☐	☐	☐
Schizophrenia	☐	☐	☐
Depression	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
Neurological disorders.	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches / migraines	☐	☐	☐
Sinus trouble	☐	☐	☐
Sores or ulcers in the mouth, cold sores	☐	☐	☐
Dry mouth	☐	☐	☐
Excessive urination	☐	☐	☐

Note: Both doctor and patients are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of patient / legal guardian Date

FOR OFFICE USE ONLY

_____ _____
Signature of Dentist/Hygienist. Date

_____ _____
Signature of Dentist/Hygienist. Date

_____ _____
Signature of Dentist/Hygienist Date

_____ _____
Signature of Dentist/Hygienist. Date