

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

### Medical History

Please check the following boxes that apply to conditions that you have or have had in the past.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Heart trouble<br><input type="checkbox"/> Angina<br><input type="checkbox"/> Heart attack<br><input type="checkbox"/> Heart surgery<br><input type="checkbox"/> Chest pain upon exertion<br><input type="checkbox"/> High or low blood pressure<br><input type="checkbox"/> Heart murmur<br><input type="checkbox"/> Rheumatic fever<br><input type="checkbox"/> Artificial heart valves<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> Swollen ankles<br><input type="checkbox"/> Infectious mononucleosis<br><input type="checkbox"/> Artificial joints<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Thyroid disease<br><input type="checkbox"/> Circulatory disorders<br><input type="checkbox"/> Blood disease<br><input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive bleeding<br><input type="checkbox"/> Hemophilia<br><input type="checkbox"/> Hepatitis A (infectious)<br><input type="checkbox"/> Hepatitis B (serum)<br><input type="checkbox"/> Blood transfusions<br><input type="checkbox"/> Liver disease<br><input type="checkbox"/> Yellow jaundice<br><input type="checkbox"/> Kidney disease<br><input type="checkbox"/> Kidney dialysis<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Rheumatism<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Chemo or radiation therapy<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Lung disease<br><input type="checkbox"/> Bronchitis<br><input type="checkbox"/> Recent weight loss<br><input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers/Colitis<br><input type="checkbox"/> Sinus trouble<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Hay fever<br><input type="checkbox"/> Swollen neck glands<br><input type="checkbox"/> AIDS/HIV +<br><input type="checkbox"/> Immunosuppressive disorders<br><input type="checkbox"/> Allergies or hives<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Nervous disorders<br><input type="checkbox"/> Psychiatric disorders<br><input type="checkbox"/> Venereal disease<br><input type="checkbox"/> Back problem<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Fainting or dizzy spells<br><input type="checkbox"/> Chemical dependency |
|---|---|---|

- |                          |                          |  |
|--------------------------|--------------------------|--|
| Yes                      | No                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any other serious illness other than the above? What: _____                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke or chew tobacco? When did you start? _____ How much per day? _____                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any allergies or adverse reactions to any medications? Please list _____<br>_____                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently taking any medications? (Please list, include over-the-counter medications.) _____               |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized? If yes, explain _____<br>_____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any surgeries? What & When: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever responded adversely to dental or medical treatment? If yes, explain _____<br>_____                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you under the care of a physician at the present time? Why? _____<br>Physician's name _____ Phone number _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Female patients: Are you now pregnant? What month: _____   |

Is there anything else we should know about your medical history? \_\_\_\_\_

**I certify that the above is accurate and complete to the best of my knowledge and that I have not intentionally omitted any information regarding my health history. I authorize Dr. Teasdale to render whatever procedures are necessary to diagnose and treat my dental needs.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

\*UPDATES

**MEDICAL HISTORY UPDATE – OFFICE USE ONLY**

| Date | Doctor | Changes? |
|------|--------|----------|
|      |        |          |
|      |        |          |
|      |        |          |
|      |        |          |