horizondentalcare
Bob Johnson, DDS

MEDICAL HISTORY

Patient Name: _____ **Birthdate:**_____

Physician Name: _____ Last Seen Date: _____

Have you been hospitalized or had a major operation? _____ For what condition? _____

Are you taking any medications, pills or drugs? _____ Please List: _____

Are you allergic to any medications or substances? _____ Please Check: ☐ Aspirin; ☐ Penicillin; ☐ Codeine; ☐ Acrylic; ☐ Metal; ☐ Latex Rubber; ☐ Other (please list) _____

WOMEN (please check): ☐ Pregnant/Trying to get pregnant; ☐ Nursing; ☐ Taking Oral Contraceptives

Please Check Yes or No:

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease	✔		Sickle Cell Disease			Ulcers			Cold Sores		
Heart Murmur*			Hemophilia			Weight Loss			Herpes		
Irregular Heartbeat			Leukemia			Diabetes			Stroke		
Angina/Chest Pain			Swelling of Limbs			Hypoglycemia			Convulsions		
Heart Attack			Lung Disease			Liver Disease			Epilepsy/Seizures		
Mitral Valve Prolapse *			Breathing Problem			Hepatitis A			Fainting/Dizziness		
Scarlet Fever			Frequent Cough			Hepatitis B or C			Glaucoma		
Rheumatic Fever*			Hay Fever			Kidney Trouble			Tumors/Growths		
Artificial Heart Valve*			Sinus Trouble			Renal Dialysis			Nervousness		
Pace Maker			Asthma			Thyroid Disease			Psychiatric Care		
Heart Surgery*			Emphysema			Arthritis/Gout			Alzheimer's Disease		
High Blood Pressure			Tuberculosis			Rheumatoid			Anesthetic Reaction		
Low Blood Pressure			Cancer			Arthritis			Allergies(Medicines)		
Blood Disease			Radiation Tx			Jaw Pain			Allergies(Pollens)		
Bruise Easily			Chemotherapy			Cortisone Tx			Hives/Rashes		
Anemia			Stomach/Intestina			Artificial Joint					
Excessive Bleeding			Disease			HIV Positive					

*if answered Yes to any of the starred conditions, please call prior to your appointment. Pre-medications may be required.

Do you have any other condition you would like us to know about? ☐ Yes ☐ No

If yes please describe: _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

_____ _____

PATIENT SIGNATURE (PARENT OR GUARDIAN) DATE