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/Intestinal			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