HORSEHEADS DENTAL

Helping People Help Themselves
Through Prevention and Education

2898 Westinghouse Road, Suite 524
Horseheads, NY 14845
(607) 739-3528
www.HorseheadsDental.com

MEDICAL HEALTH HISTORY

How would you describe your general health? □ Excellent □ Good □ Fair □ Poor
Are you under the care of a physician? □ Yes □ No (If yes, please explain)

_____

_____

Physician's
Name_____Address_____(___)_____
Phone

Family physician's
Name_____Address_____(___)_____
Phone

Have you ever been hospitalized or had a major operation? □ Yes □ No Discuss
Have you ever had a serious injury to your head or neck? □ Yes □ No Discuss
Are you taking any medications, pills or drugs? □ Yes □ No What?
Do you now have or have you ever had any of the following? Please circle all that apply.

*If any of the asterisked conditions apply, please call prior to your appointments. Premedication may be required.

Heart trouble/disease	Bruise easily	Emphysema	Yellow jaundice	Cold sores
Heart murmur*	Anemia	Tuberculosis	Kidney problems	Fever blisters
Irregular heart beat	Excessive bleeding	Cancer	Renal dialysis	Herpes
Angina/chest pain	Sickle cell disease	X-ray treatments (radiation)	Thyroid disease	Stroke
Heart attack/failure	Hemophilia (bleeding problems)	Chemotherapy	Parathyroid disease	Convulsions
Congenital heart disorder	Leukemia	Stomach/intestinal disease	Arthritis/gout	Epilepsy or seizures
Mitral valve prolapse*	Recent blood transfusion	Ulcers	Rheumatism	Fainting or dizziness
Scarlet fever	Swelling of limbs	Recent weight loss	Pain in jaw joints	Glaucoma
Rheumatic fever*	Lung disease	Frequent diarrhea	Cortisone medicine	Tumors or growths
Artificial heart valve*	Breathing problem	Diabetes	Artificial joint*	Nervousness
Heart pace maker*	Shortness of breath	Excessive thirst	Venereal disease	Psychiatric care
Heart surgery*	Frequent cough	Hypoglycemia	AIDS	Alzheimer's disease
High blood pressure	Hay fever	Liver disease	HIV positive	Allergies (medicine)
Low blood pressure	Sinus trouble	Hepatitis A	Genital herpes	Allergies (pollen/dust)
Blood disease	Asthma	Hepatitis B or C	Osteoporosis	Hives or rash

Have you ever had any other serious illness not listed above? □ Yes □ No Discuss_____
Have you ever had to take any medications before your dental appointment? □ Yes □ No _____
Are you allergic or sensitive to any of the following medications? Please circle all that apply.

Penicillins	Aspirin	Lidocaine	Novocaine
Erythromycins	Tylenol	Xylocaine	Valium
Tetracyclines	Codeine	Carbocaine	Latex

List other medications you are allergic or sensitive to_____
Do you smoke? □ Yes □ No How long?_____Number of packs per day_____
For women, are you: □ Pregnant/trying to get pregnant? Delivery date?
□ Taking birth control pills?
□ Taking hormone replacement medications?

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

_____ _____

Signature of: □ Adult patient □ Father □ Mother □ Spouse □ Partner □ Guardian Date