Holland *family* Dentistry
MEDICAL HISTORY

Name _____

Date of Birth_____Age _____

Occupation _____

Answer Yes or No (check appropriate box)

Have you ever been diagnosed with:

High blood pressure	☐ Yes	☐ No
Heart disease – angina	☐ Yes	☐ No
- heart attack	☐ Yes	☐ No
- irregular heart beat	☐ Yes	☐ No
- heart murmur	☐ Yes	☐ No
- rheumatic heart disease	☐ Yes	☐ No
- other	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Lung disease – asthma	☐ Yes	☐ No
- emphysema	☐ Yes	☐ No
- pneumonia	☐ Yes	☐ No
- bronchitis	☐ Yes	☐ No
Bleeding or Clotting disorder	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Psychiatric problems - anxiety	☐ Yes	☐ No
- other	☐ Yes	☐ No
Nervous system disease - depression	☐ Yes	☐ No
- epilepsy	☐ Yes	☐ No
- migraines	☐ Yes	☐ No
- other	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
Gastrointestinal disease	☐ Yes	☐ No
Aids or HIV Infection	☐ Yes	☐ No
Joint Replacement	☐ Yes	☐ No
Are you or Could you be pregnant	☐ Yes	☐ No
Are you taking birth control pills	☐ Yes	☐ No
Other medical problems	☐ Yes	☐ No

Allergic to:

Local Anesthetic	☐ Yes	☐ No
Antibiotics	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Other	☐ Yes	☐ No

Please list _____

Physician's Name _____

Phone Number _____

List all medications you are taking _____

List past surgical procedures: _____

When was your last dental visit? _____

Previous Dentist Name _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

When was your last Full Mouth X-Ray taken? _____

Notes: _____

Please list other medical problems _____

Do you smoke ☐ Yes ☐ No – If yes, how much _____ for how long _____

Do you use alcohol or recreational drugs ☐ Yes ☐ No – If yes, how much _____ how often _____

Do you regularly use aspirin ☐ Yes ☐ No – If yes, how much _____ how often _____

Dr./Hygienist Notes: _____