CHANDLER
Family Dentistry

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*Asterick indicates required information.

MEDICAL HEALTH HISTORY

*Patient's Name: ______________________ *Date of Birth: _ _ /_ _ /_ _ _ _

Do you have any of the following? Please check all that apply.

- ☐ Abnormal bleeding after extractions, surgery, or trauma
- ☐ AIDS or HIV Positive
- ☐ Alcoholism
- ☐ Allergies or hives
- ☐ Anemia or blood disorders
- ☐ Arthritis
- ☐ Artificial joint or valve
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer or tumor
- ☐ Diabetes
- ☐ Emotional condition
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Hay fever or sinus trouble
- ☐ Heart ailment or angina
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Hepatitis or other liver disease
- ☐ Herpes or cold sores
- ☐ High or low blood pressure
- ☐ Kidney disease
- ☐ Migraine headaches or frequent headaches
- ☐ Neurologic condition
- ☐ Pacemaker
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Tuberculosis or other lung problems

Do you smoke or use chewing tobacco? Yes: ☐ No: ☐

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Aspirin
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Codeine or other narcotics
- ☐ Latex materials
- ☐ Local anesthetics ("Novocain")
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Other: ______________________

Are you taking any of the following?

- ☐ Antibiotics or sulfa drugs
- ☐ Anticoagulants (blood thinners)
- ☐ Antidepressants or tranquilizers
- ☐ Aspirin
- ☐ Cortisone or other steroids
- ☐ High blood pressure medicine
- ☐ Insulin, Orinase, or other diabetes drug
- ☐ Nitroglycerin
- ☐ Osteoporosis (bone density) medicine
- ☐ Other: ______________________

Women:

- ☐ May be pregnant
  Expected delivery date: ______________________
- ☐ Taking hormones or contraceptives

Physician's Name: ______________________ Phone: ______________________

Pharmacy: ______________________ Phone: ______________________

Do you have artificial joint(s), valve(s): Yes: ☐ No: ☐ If YES, please provide additional information: ______________________

If YES, do you need to take an antibotic prior to dental treatment? Yes: ☐ No: ☐

Do you have any disease, condition, or problem not listed on this page? ______________________

Please add anything else you would like us to know: ______________________

Are you taking ANY drugs, medications, or treatments at this time? Please list below: ______________________

Over-the-Counter (OTC) medications (such as Asprin, Advil, allergy medications, sleeping aids, etc.)?: ______________________

Vitamins, natural or herbal preparations and/or dietary supplements?: ______________________

Have you been hospitalized or had surgery in the last three years? Yes: ☐ No: ☐ If YES, please give reasons and dates: ______________________

*Patient's Signature (or parent): ______________________ *Date: ____ / ____ / ____