Patient Name: _____ Date of Birth: _____

Today's Date: _____

Medical History

- Heart Attack ☐ if yes when: _____
- Cardiac Bypass ☐ if yes when: _____
- High Blood Pressure ☐
- Low Blood Pressure ☐
- Chest Pain (Angina) ☐
- Heart Murmurs ☐
- Mitral Valve Prolapse ☐
- Artificial Valves ☐
- Rheumatic Fever/ Heart Disease ☐
- Other Heart Problems ☐
- Comments: _____

_____

_____

- Diabetes - Type 1 ☐
- Diabetes - Type 2 ☐
- Thyroid Problems ☐
- Other Gland Problems ☐
- Seasonal Allergies ☐
- Sinus Trouble ☐
- Shortness of Breath ☐
- Persistent Cough ☐
- TB or Lung Disease ☐
- Asthma ☐
- Emphysema ☐
- Cough up Blood ☐
- Tobacco Smoking ☐
  Vaping ☐
  Chewing ☐
- Immune Disorder ☐
- HIV/AIDS ☐

- Blood Thinners ☐ if yes name of drug: _____
- History of Stroke ☐ if yes when: _____
- Head Injury ☐
- Fainting Spells ☐
- Chronic Headaches ☐
- Epilepsy/Seizures ☐
- Anemia ☐
- Hemophilia ☐
- Bleeding Disorder ☐
- Stomach Pain ☐
- Acid Reflux/Heart Burn ☐
- History of Ulcers ☐
- Colitis ☐
- Artifical Joints ☐ If yes Type and date: _____
- Arthritis ☐
- Hepatitis/Jaundice/ Liver Disease ☐
- Venereal Disease ☐
- Radiation Treatment ☐
- Cancer ☐ Type _____
- Kidney or Bladder Disease ☐
- Glaucoma ☐
- Depression ☐
- Anxiety ☐
- History of Psychiatric Drugs ☐
- Other _____

_____

_____

List all Medications: prescription & over the counter: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

- **Flouride Supplements** ☐
- **Women:** Are you pregnant ☐
  Are you nursing ☐
- Bone Strengthening Drug ☐

If Yes name: _____

_____

_____

Are you allergic to or have had any reactions to any of the following:

- Local Anesthetics (I.E. Novocaine) ☐
- Penicillin or any other Antibiotics ☐
- Codeine ☐
- Latex ☐
- Other: _____

_____

_____

~over~