NEW HEIGHTS DENTAL

MEDICAL HISTORY

Health problems that you may have, or medication you may be taking can have an important interrelationship with the dentistry you receive. Thank you for answering the following questions:

Are you under a physician's care now? ___Yes ___No If yes, please explain _____

Have you been hospitalized or had a major operation recently? ___Yes ___No If yes, please explain_____

Have you had a head or neck injury? ___Yes ___No If yes, please explain_____

Please list all medication that you are presently taking_____

Do you use tobacco? ___Yes ___No Do you use controlled substances? ___Yes ___No

Women are you Pregnant or trying to get pregnant ___Yes ___No Taking oral contraceptives? ___Yes ___No Nursing ___Yes ___No

Are you allergic to any of the following? ___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Local Anesthetic

___Other please list _____

Please **circle** only the Health problems that you may have

Aids/HIV Positive	Diabetes	Hemophilia	Renal Dialysis
Anaphylaxis	Drug Addiction	Hepatitis A B C	Rheumatic Fever
Anemia	Easily Winded	Herpes	Rheumatism
Angina	Emphysema	High Blood Pressure	Sinus Trouble
Artificial Joint	Epilepsy or Seizures	Hives or Rash	Stomach/Intestinal Disease
Asthma	Excessive Bleeding	Hypoglycemia	Stroke
Blood Disease	Fainting Spells/Dizziness	Kidney Problems	Swelling of Limbs
Bruise Easily	Frequent Headaches	Leukemia	Thyroid Disease
Cancer	Genital Herpes	Liver Disease	Tuberculosis
Chemotherapy	Glaucoma	Low Blood Pressure	Tumors or Growths
Chest Pains	Hay Fever	Lung Disease	Ulcers
Cold Sores/Fever Blisters	Heart Attack/Failure	Mitral Valve Prolapsed	Venereal Disease
Congenital Heart Disorder	Heart Murmur	Pain in Jaw Joints	Yellow Jaundice
Convulsions	Heart Pace Maker	Parathyroid Disease	
	Heart Trouble/Disease	Psychiatric Care	
Do you take		Radiation Treatments	
Bisphosphonate medication for Osteoporosis		Recent Weight Loss	

Any Health issues not listed above_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Dr. Sweeney of any changes in my medical status.

Print Name_____

Signature of Patient, Parent, or Guardian_____Date_____

New Address? ___Yes ___No If yes, _____

Cell Phone_____E-mail address_____HH UPDATE _____

HH UPDATE_____HH UPDATE_____