*Medical History

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD/OR PRESENTLY HAVE:

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ Artificial Heart Valve
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Chest Pain
- ☐ Bleeding Problems
- ☐ Arrhythmias
- ☐ Heart Pacemaker
- ☐ Rheumatic Fever

- ☐ Glaucoma
- ☐ Cancer
- ☐ Radiation Treatment Conditions
- ☐ Chemotherapy
- ☐ Organ Transplant
- ☐ Artificial Joints (hip, knee)
- ☐ Port

- ☐ Liver Disease
- ☐ Kidney Disorder
- ☐ Ulcers
- ☐ Gerd

- ☐ Tuberculosis (T.B.)
- ☐ Hepatitis
- ☐ Aids/HIV positive

- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Immune Disorder
- ☐ Pregnant-DUE_____
- ☐ Breast Feeding

- ☐ Epilepsy or Seizures
- ☐ Depression
- ☐ Panic Attack
- ☐ Multiple Sclerosis
- ☐ Headaches
- ☐ Substance Abuse
- ☐ Physical/Mental Impairment

- ☐ Respiratory Problems
- ☐ snoring/sleep apnea
- ☐ COPD
- ☐ Asthma
- ☐ Hay Fever
- ☐ Emphysema
- ☐ CPAP
- ☐ Allergies

Other not listed:

Any problems with anesthesia ☐ yes ☐ no

Any allergies to medicine, food, pine nuts/nuts, or any other:

☐ Pre-med prior to dental treatment Pharmacy Phone #:

Please list all medications you are taking, including non-prescription:

Emergency Contact Phone Number