West Village Dental Studio
Family and Cosmetic Dentistry

MEDICAL HEALTH HISTORY

Medical Conditions: (Please check any that apply)

- ❑ Cancer or tumor:_____
- ❑ Heart ailment or Chest Pain
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve:_____
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition_____
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Autoimmune condition: _____
- ❑ Hearing impaired

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Do you drink alcohol? ❑ yes ❑ no

If yes, How many drinks per week? _____

Allergies/Adverse Reactions:

- ❑ Latex
- ❑ Penicillin/Amoxicillin/Augmentin
- ❑ Local anesthetics ("Novocain")
- ❑ Nitrous Oxide
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Current/Recent Medications:

- ❑ Aspirin
- ❑ Inhaler for Asthma (albuterol)
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Birth Control
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

_____

Women Only:

Are you Pregnant? ❑ yes ❑ no

Expected delivery date: _____

Nursing?_____

Do you have any disease, condition, or problem not listed above?_____

Please add anything else you would like us to know about:_____

Physician's Name:_____ Physician's Phone number:_____

Pharmacy Name:_____ Pharmacy Phone Number:_____

Signature of Patient (or parent if minor) _____ Date _____

Dentist Signature:_____ Date:_____