# Dental Health History

Date:_____

Patient Name _____ Birthdate:_____

## Medical History

Physician's Name: _____ Date of last visit:_____

**Any serious Illnesses or Operations?** Yes No if Yes Describe:_____

**Are you pregnant?** Yes No **Nursing?** Yes No **Birth Control?** Yes No

Check (✓) if you have had problems with any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | AIDS | | Cortisone treatments | | High blood pressure | | Scarlet Fever |
| | Anemia | | Persistent cough | | HIV positive | | Shortness of breath |
| | Arthritis, Rheumatism | | Cough up blood | | Jaw pain | | Skin Rash |
| | Artificial heart valves | | Diabetes Type: | | Kidney disease | | Stroke |
| | Artificial joints | | Epilepsy | | Liver disease | | Swelling of feet/ankles |
| | Asthma | | Fainting | | Mitral valve problems | | Thyroid problems |
| | Back problems | | Glaucoma | | Nervous problems | | Tobacco Habit |
| | Blood disease | | Headaches | | Pacemaker | | Tonsillitis |
| | Cancer | | Heart Murmur | | Psychiatric care | | Tuberculosis |
| | Chemical dependency | | Heart problems | | Radiation treatment | | Ulcer(s) |
| | Chemotherapy | | Hemophilia | | Respiratory disease | | Venereal disease |
| | Circulatory problems | | Hepatitis | | Rheumatic Fever | | Other |

| MEDICATIONS | | ALLERGIES |
|---|---|---|
| Current Medications: | | Aspirin |
| | | Barbiturates (sleeping pills) |
| | | Codeine |
| | | Local Anesthetic |
| | | Penicillin |
| Pharmacy name: | | Sulfa |
| Phone number: | | Other: |

The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Christopher D. Elson or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____

Date:_____