STONEHENGE
FAMILY & COSMETIC DENTISTRY

MEDICAL HISTORY

Patient: _____

NO YES Allergy - Aspirin

NO YES Allergy - Codeine

NO YES Allergy – Latex

NO YES Allergy – Local Anesthetic

NO YES Allergy – Penicillin

NO YES Allergy – Sulfa

List any other allergies:

_____

_____

NO YES Arthritis / Rheumatism / Gout

NO YES Artificial Joint / Bones

NO YES Asthma

NO YES Cancer If Yes, Date: _____

NO YES Chemotherapy

NO YES Diabetes

NO YES Emphysema

NO YES Glaucoma

NO YES Radiation Treatment (Xray/Cobalt)

NO YES Shortness of Breath (Breathing Problems)

NO YES Sinus Trouble

NO YES Stroke

NO YES Thyroid Problems

NO YES Tuberculosis

NO YES Tumor / growth on head / neck

NO YES Ulcer

NO YES Do you Smoke?

NO YES Do you drink Alcohol?

NO YES High Sugar Intake?

NO YES Abnormal (High/Low Blood Pressure)

NO YES AIDS/HIV

NO YES Anemia /Bleeding Problems

NO YES Artificial Heart Valve

NO YES Blood Disease

NO YES Congenital Heart Lesions

NO YES Heart Problems

NO YES Pacemaker

NO YES Epilepsy

NO YES Fainting / Dizziness

NO YES Headaches (Frequent)

NO YES Hepatitis

NO YES Herpes

NO YES Kidney Disease

NO YES Liver Disease

NO YES Nervous Problems

NO YES Psychiatric Care

List any other medical issues you have: _____

_____

List any serious illness / surgeries / hospitalizations:

_____

_____

List any medications you are taking:

_____

_____

NO YES Has your medical doctor advised you to take a pre-med before dental appointments?

NO YES Pregnant

NO YES Nursing

Signature: _____

Date: _____