



Medical History – Highland Park Family Dentistry

Last: _____ First: _____ M.I. _____ Birthdate: _____

Any History Of: (please circle y or n)

Heart Problems.....	Y	N	Bronchitis.....	Y	N	Heart Valve Problems.....	Y	N
High Blood Pressure.....	Y	N	Fever Blisters/Herpes.....	Y	N	Nose Obstructions.....	Y	N
Rheumatic Fever.....	Y	N	Stroke.....	Y	N	Hypoglycemia.....	Y	N
Asthma.....	Y	N	Thyroid Problems.....	Y	N	Hyperglycemia.....	Y	N
Blood Transfusions.....	Y	N	Sinus Problems.....	Y	N	Prostate Problems.....	Y	N
Hepatitis.....	Y	N	Kidney or Liver Disease...	Y	N	Lung Disease.....	Y	N
Artificial Joints.....	Y	N	Glaucoma.....	Y	N	High Cholesterol.....	Y	N
Heart Murmur.....	Y	N	Allergies.....	Y	N	Cancer.....	Y	N
Cortisone or ACT II.....	Y	N	Prolonged Bleeding.....	Y	N	Ulcers.....	Y	N
Anemia.....	Y	N	Epilepsy/Convulsions.....	Y	N	Emphysema.....	Y	N
Tested Positive for HIV.....	Y	N	Arthritis.....	Y	N	Fainting/Dizzy Spells.....	Y	N
Psychiatric Treatment.....	Y	N	Diabetes.....	Y	N	Epinephrine Sensitivity.....	Y	N

• Do you have, or have you had, any disease, conditions, or problems not listed? If yes, please specify: _____

• Are you being treated by a physician now or have been in the last 6 months? If yes please specify: _____

• Are you taking any medications? If yes, please specify: _____

• Are you allergic to any medications? If yes, please specify: _____

• Any recent illnesses? If yes, please specify: _____

• For women only: *Are you pregnant? Yes No *Are you nursing? Yes No

I understand the above information is necessary to provide my dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

Patient Signature: _____ Date: _____

Parent or Responsible Party Signature: _____ Relationship to Patient: _____

Dentist's Signature: _____ Date: _____