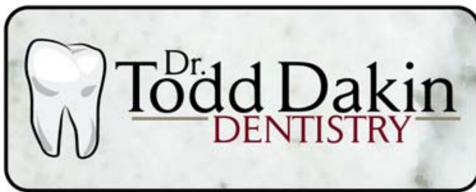

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Phone: *530-7004* Fax: *543-6849*
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MEDICAL HEALTH HISTORY

Name: Address:	Do You Have Dental Insurance? Insurance Company Name:
	Plan Number:
Phone: H W	MSI Health Card #:
Date of Birth:	Occupation:
E-Mail Address:	Today'sDate:
Would you like to receive appointment reminders via e-mail? YES ☐ NO ☐	

MEDICAL ALERT	Condition:	Premedication:

		YES	NO
1.	Are you currently under the care of a physician or being treated for any medical condition?	☐	☐
	If yes, please explain. Physician's Name : Phone :		
2.	Are you presently taking any PRESCRIPTION or NON-PRESCRIPTION drugs? Or have you recently taken any?	☐	☐

	If yes, please list:		
3.	Have you been hospitalized or had a serious illness or operation?	☐	☐
4.	Have you ever reacted adversely to any of the following?		
	Antibiotics - Penicillin.	☐	☐
	Sulfonamide.	☐	☐
	other antibiotics.	☐	☐
	Aspirin.	☐	☐
	Barbiturates (sleeping pills).	☐	☐
	Codeine.	☐	☐
	Local Anesthetic (freezing).	☐	☐
	Any other medication, please list.	☐	☐
5.	Have you ever been advised against taking any specific type of medication?	☐	☐
6.	Do you have/or have had any of the following?		

Asthma.	Y☐	N☐	Hay Fever.	Y☐	N☐
Food Allergies.	Y☐	N☐	Metal or Latex Allergies.	Y☐	N☐
Skin Rashes.	Y☐	N☐	Hives.	Y☐	N☐
Any other allergic condition.	Y☐	N☐			

7.	Does any family member have diabetes?	☐	☐
8.	Do you bleed EXCESSIVELY from a cut or injury, or bruise easily?	☐	☐
9.	Have you ever had any injury, surgery, or radiation therapy to your face or jaws?	☐	☐
10.	Do you wear eyeglasses or contact lenses?	☐	☐
11.	Do you have any hearing difficulties?	☐	☐
12.	Do you smoke or use any other forms of tobacco?	☐	☐
13.	INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:		

	Yes	No		Yes	No
A.I.D.S./HIV	☐	☐	Artificial joints (hip, knee)	☐	☐
Arthritis/ rheumatism	☐	☐	Lung disease	☐	☐
Blood disorders	☐	☐	Bronchitis	☐	☐
Cancer	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Emphysema	☐	☐
Kidney disease	☐	☐	Epilepsy or seizures	☐	☐
Head/neck injuries	☐	☐	Fainting or dizzy spells	☐	☐
Heart pacemaker	☐	☐	Liver disease	☐	☐
Congenital heart lesions	☐	☐	Hepatitis A	☐	☐
Artificial heart valve	☐	☐	Hepatitis B	☐	☐
Heart disease or attack	☐	☐	Hepatitis C	☐	☐
Hypertension	☐	☐	Mental/nervous disorder	☐	☐
Heart surgery	☐	☐	Stomach/ intestinal problems	☐	☐
Heart murmur	☐	☐	Ulcers	☐	☐
Mitral valve prolapse	☐	☐	Sinus trouble	☐	☐
Organ transplant/ medical transplant	☐	☐	Stroke	☐	☐
Rheumatic/ Scarlet fever	☐	☐	Thyroid disease	☐	☐
Radiation treatment/ chemotherapy	☐	☐			

Other ____________________

14.	WOMEN ONLY:		
	Are you pregnant or suspect you might be?	☐	☐
	If yes, what is the expected birth date? ________		
	Are you taking any birth control pills?	☐	☐
15.	Do you currently have, or have you had in the past, any disease, condition, or problem not listed above? ____________________	☐	☐
16.	Is there anything else about your health we should be made aware of? ____________________	☐	☐
17.	Do you wish to speak to the Doctor privately about any problem or medical condition?	☐	☐