Medical History Form

Jonestown DENTAL
gentle dental care for the entire family

Name _____ Home/Cell Number _____

Medical Doctor & Phone #: _____ Date of Birth _____

Please check all boxes that are positive:

- ☐ Rheumatic or Scarlet Fever
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ High or Low Blood Pressure (Circle One)
- ☐ High Cholesterol
- ☐ Coronary Artery Disease
- ☐ Chest Pain or Angina
- ☐ Heart Attack
- ☐ Stroke
- ☐ Transient Ischemic Attacks
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Hepatitis / Jaundice
- ☐ Anemia - Sickle Cell or Iron Deficiency
- ☐ Do you bleed or bruise easily?
- ☐ Seizure Disorders
- ☐ Have any Hip or Knee replacements?
- ☐ Diagnosed with Cancer or Leukemia?
- ☐ Diagnosed with any neurological problems?
- ☐ Other Heart Problems _____
- ☐ Arthritis
- ☐ Emphysema
- ☐ Tuberculosis (TB)
- ☐ Asbestosis
- ☐ Sinus Problems
- ☐ Hay Fever
- ☐ Difficulty Breathing
- ☐ Do you Smoke? How many packs and for how long? _____
- ☐ Diagnosed with any connective tissue disease?
- ☐ Diagnosed with any infections or sexually transmitted diseases, including but not limited to HIV, AIDS, Hepatitis, Gonorrhea or Syphilis?
- ☐ Drink alcohol? If yes, how much and how often? _____
- ☐ Do you or have you ever, used heroin, cocaine, marijuana or any other recreational drugs?
- ☐ Have you ever taken Phen-Fen or Redux?

Have you ever been hospitalized? If yes, list the reason and the dates. _____
Have you ever suffered any trauma to the face? _____
Have you ever had any surgery? If yes, list the procedure and dates. _____
Are you currently under care of a physician or psychiatrist for any reason? If yes, please list reason. _____
Are you currently pregnant? If yes, how many weeks? _____
Please list ALL current medications you are taking both prescription and over the counter, including birth control pills. _____

Please list ALL allergies to foods, medications, latex, anesthetics, and or environmental substances. _____

My signature below states that I have completely read and completed this medical history form for myself/child. There are no omissions; I understand that not revealing my complete medical history may place myself/child at risk during dental treatment.

Patient or Guardian	Date	Update/Date	Update/Date
Doctor or Hygienist	Date	Update/Date	Update/Date