CHEHALEM DENTAL

Name: _____ **MEDICAL HISTORY FORM**

Birthdate: _____

1. Physicians name: _____ Phone: (_____) _____
2. Have you been treated or hospitalized for any reason in the past 5 years? If so please explain:

   _____

   _____
3. Please list all current medications including prescription and over the counter medications:

   _____

   _____

   _____
4. Please list all allergies and substances that you have had reactions to:

   _____

   _____

   _____
5. If you currently or in the past have smoked cigarettes or marijuana please let us know how often:

   _____
6. If you currently or in the past have used illegal drugs, please describe usage and frequency:

   _____
7. Please mark yes or no to indicate current or history of issues to each of the following:

	Yes	No		Yes	No		Yes	No
Heart attack	☐	☐	Celiac	☐	☐	AIDS/HIV positive	☐	☐
Chest pain	☐	☐	Glaucoma	☐	☐	Cold sores	☐	☐
Congenital heart disease	☐	☐	Emphysema	☐	☐	Hemophilia	☐	☐
Heart murmur	☐	☐	COPD	☐	☐	Sickle cell disease	☐	☐
High blood pressure	☐	☐	Tuberculosis	☐	☐	Bruise easily	☐	☐
Low blood pressure	☐	☐	Asthma	☐	☐	Neurological disorders	☐	☐
Artificial heart valve	☐	☐	Latex sensitivity	☐	☐	Epilepsy or seizures	☐	☐
Rheumatic fever	☐	☐	Sinus trouble/infection	☐	☐	Fainting or dizzy spells	☐	☐
Cortisone medication	☐	☐	Radiation therapy	☐	☐	Nervous/anxious	☐	☐
Stroke/TIA	☐	☐	Chemotherapy	☐	☐	Psychiatric/psychological care	☐	☐
Artificial joints	☐	☐	Tumors	☐	☐			
Diabetes	☐	☐	Hepatitis	☐A	☐B	☐C		

8. Please list any disease/illness not listed here: _____
9. Women: are you pregnant or think you could be pregnant ☐Yes ☐No Are you nursing? ☐Yes ☐No

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medications.

Patient / Guardian Signature: _____ Date: _____

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