Weber Dental
Family Dental Care
Because You Deserve a Healthy Smile

MEDICAL HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____
Name of your physician: _____ **Date of last Medical Exam:** _____

MEDICATIONS (include VITAMINS):

_____
_____
_____

ALLERGIES: _____

CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

Yes No Have you had any change in your health within the last year? Explain: _____
Yes No Have you been hospitalized or had a serious illness in the last 5 years? _____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

Yes	No	Chest Pains	Yes	No	Dizziness
Yes	No	Swollen Ankles	Yes	No	Ringing in ears
Yes	No	Shortness of breath	Yes	No	Frequent Headaches
Yes	No	Recent weight loss, fever, night sweats	Yes	No	Fainting spells
Yes	No	Persistent cough, coughing up blood	Yes	No	Blurred Vision
Yes	No	Bleeding problems, bruising easily	Yes	No	Seizures
Yes	No	Sinus Problems	Yes	No	Excessive thirst
Yes	No	Difficulty swallowing	Yes	No	Frequent urination
Yes	No	Constipation, blood in stools	Yes	No	Dry Mouth
Yes	No	Frequent vomiting, nausea	Yes	No	Jaundice
Yes	No	Difficulty urinating, blood in urine	Yes	No	Joint pain, stiffness
			Yes	No	Sleep apnea or chronic snoring

DO YOU HAVE OR HAVE YOU HAD?

Yes	No	Heart disease	Yes	No	HIV positive or AIDS-ARC
Yes	No	Heart attack, heart defects	Yes	No	Tumors, Cancer
Yes	No	Heart murmur	Yes	No	Arthritis, rheumatism
Yes	No	Rheumatic fever	Yes	No	Eye disease
Yes	No	Stroke, hardening of arteries	Yes	No	Skin disease
Yes	No	High Blood Pressure	Yes	No	Anemia
Yes	No	TB, emphysema or other lung diseases	Yes	No	VD (syphilis or gonorrhea)
Yes	No	Hepatitis, A B C	Yes	No	Herpes
Yes	No	Stomach problems, ulcers	Yes	No	Kidney, bladder diseases
Yes	No	Diabetes	Yes	No	Thyroid, adrenal diseases
Yes	No	Family History of diabetes, heart problems, cancer			

DO YOU HAVE OR HAVE YOU HAD?

Yes	No	Surgeries _____	Yes	No	Radiation Treatments
Yes	No	Blood Transfusion_____	Yes	No	Chemotherapy
Yes	No	Artificial Joint _____	Yes	No	Prosthetic heart valve
Yes	No	Contact Lenses _____	Yes	No	Pacemaker
Yes	No	Psychiatric Care _____			

WOMEN ONLY:

Yes	No	Birth Control Pills	Yes	No	Pregnant or nursing

DO YOU TAKE OR HAVE TAKEN?

Yes	No	Recreational drugs	Yes	No	Phen Phen diet Pills or any other diet pills
Yes	No	Alcohol	Yes	No	Fosamax or other Bone Building Medicines
Yes	No	Tobacco in any forms			

Do you have or have you had any other diseases or medical problems NOT listed on this form?

Have you ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment?