Hanover Road Dental Health

Patient Medical History

Patient's Name: _____ Date of Birth: _____

Physician Name: _____ Physician Phone: _____

Date of last physical exam: _____

Pharmacy: _____ Pharmacy Phone: _____

Do you smoke or use tobacco? _____

If female, please answer the following:

Birth control? _____ If yes, type: _____

Are you pregnant? _____ If yes, # of week's _____

Are you nursing? _____

Allergies: Are you allergic to any of the following? Please Circle:

Aspirin	Metals	Shellfish
Codeine	Penicillin	Bleach
Dental Anesthetics	Amoxicillin	Other
Erythromycin	Tetracycline	If other, please specify:
Jewelry	Sulfa	_____
Latex	Pine Nuts	_____

Please list any prescriptions/over the counter medications you are taking:
(Please include supplements and birth control)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any of the conditions past or present that apply to you:

□ Heart Attack
□ Stroke
□ High Blood Pressure
□ Low Blood Pressure
□ AIDS
□ Autism Spectrum Disorder
□ Attention Deficit Disorder
□ Epilepsy
□ Atrial Fibrillation
□ Ventricular Fibrillation
□ Abnormal Bleeding
□ Anemia
□ Artificial Joints
□ Emphysema
□ Difficulty Breathing
□ COPD
□ Asthma
□ Sinus Problems
□ Frequent Headaches
□ Glaucoma
□ Kidney Problems
□ Dementia/Alzheimer's
□ Diabetes (Type _____)
□ Hepatitis (Type ____)
□ Prior Periodontal Treatment
□ Stomach Problems
□ Tuberculosis
□ Immune Deficiency
□ HIV
□ Congenital Heart Defect
□ Artificial Heart Valve
□ Pace Maker
□ HPV
□ Seizures
□ Fainting Spells
□ Cancer
□ History of Oral Cancer
□ Chemotherapy
□ Radiation Therapy
□ Recent Hospitalization
□ Allergies
□ History of Psychiatric Treatment
□ Drug/Alcohol Abuse
□ Depression
□ Anxiety
□ Hypothyroidism
□ Hyperthyroidism
□ High Cholesterol
□ Recurrent Oral Sores

Patient or Guardian's Signature: _____ Date:_____