Medical Health History

ARBOR LAKES DENTAL

Patient Name _____ DOB: _____

Please check Yes or No for those that apply to you.

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Drug Addiction	☐	☐	Kidney Disease	☐	☐	Seizures
☐	☐	Arthritis	☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐	Stomach Problems
☐	☐	Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Low Blood Pressure	☐	☐	Stroke
☐	☐	Artificial Joints	☐	☐	Fainting	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Disease
☐	☐	Asthma	☐	☐	Glaucoma	☐	☐	Nervous / Depression	☐	☐	Tuberculosis
☐	☐	Blood Disease	☐	☐	Heart Conditions	☐	☐	Pacemaker	☐	☐	Ulcers
☐	☐	Bruise Easily	☐	☐	Heart Murmur	☐	☐	Periodontal Disease	☐	☐	Venereal Disease
☐	☐	Cancer	☐	☐	Heart Surgery	☐	☐	Radiation (Head / Neck)	***Women Only***		
☐	☐	Chemotherapy	☐	☐	Hepatitis A B C	☐	☐	Respiratory Problems	☐	☐	*Birth Control*
☐	☐	COPD	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever	☐	☐	*Nursing*
☐	☐	Diabetes	☐	☐	HIV Positive	☐	☐	Rheumatism	☐	☐	*Pregnant*
☐	☐	Dizziness	☐	☐	Jaundice	☐	☐	Scarlet Fever	*Delivery Date* _____		

Any conditions not listed above? _____

Have you ever taken pre-medication before a dental appointment? _____ Yes _____ No

Do you have any of the following drug allergies?

Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Latex	☐	☐	Percodan
☐	☐	Codeine	☐	☐	Anesthetic	☐	☐	Penicillin
☐	☐	Darvon	☐	☐	Nitrous Oxide	☐	☐	Antibiotics
☐	☐	Erythromycin	☐	☐	Sulfa	☐	☐	Other Allergies

Please check any of the following drugs you have used at any time:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Fosamax	☐	☐	Didronel	☐	☐	Zometa	☐	☐	Boniva
☐	☐	Aredia	☐	☐	Actonel	☐	☐	Skelid	☐	☐	Bisphosphonates

List ALL Medications you currently take. (Prescription and Over-the-counter) Attach list, if needed

_____ _____ _____ _____

_____ _____ _____ _____

I certify that the information recorded on this medical form is correct. I understand it is my responsibility to notify Arbor Lakes Dental of any changes. I understand that if I withhold information regarding allergies, medical conditions, medications or supplements; I agree not to hold Arbor Lakes Dental or its employees liable in the event of death or injury.

Signature (Patient / Guardian) _____ Date: _____

Clinician Signature: _____