



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:

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

Patient or Guardian's Signature: _____ Date: _____