# Medical History – Highland Park Family Dentistry

Last:_____ First:_____ M.I._____ Birthdate:_____

## Any History Of: (please circle y or n)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Problems..... | Y | N | Bronchitis..... | Y | N | Heart Valve Problems..... | Y | N |
| High Blood Pressure..... | Y | N | Fever Blisters/Herpes..... | Y | | Nose Obstructions..... | Y | N |
| Rheumatic Fever..... | Y | N | Stroke..... | Y | N | Hypoglycemia..... | Y | N |
| Asthma..... | Y | N | Thyroid Problems..... | Y | | Hyperglycemia..... | Y | N |
| Blood Transfusions..... | Y | N | Sinus Problems..... | Y | N | Prostate Problems..... | Y | N |
| Hepatitis..... | Y | N | Kidney or Liver Disease... | Y | | Lung Disease..... | Y | N |
| Artificial Joints..... | Y | N | Glaucoma..... | Y | N | High Cholesterol..... | Y | N |
| Heart Murmur..... | Y | N | Allergies..... | Y | | Cancer..... | Y | N |
| Cortisone or ACT II..... | Y | N | Prolonged Bleeding..... | Y | N | Ulcers..... | Y | N |
| Anemia..... | Y | N | Epilepsy/Convulsions..... | Y | | Emphysema..... | Y | N |
| Tested Positive for HIV..... | Y | N | Arthritis..... | Y | N | Fainting/Dizzy Spells..... | Y | N |
| Psychiatric Treatment..... | Y | N | Diabetes..... | Y | | Epinephrine Sensitivity..... | Y | N |

- **Do you currently use tobacco products (smoke or chew)? Y N Do you currently use vape products? Y N**

  **If yes, how much or how often:**_____

- Do you have, or have you had, any disease, conditions, or problems not listed? If yes, please specify: _____

  _____

- Are you being treated by a physician now or have been in the last 6 months? If yes please specify:_____

  _____

- Are you taking any medications? If yes, please specify:_____

  _____

- Are you allergic to any medications? If yes, please specify:_____

  _____

- Any recent illnesses? If yes, please specify:_____

- For women only: *Are you pregnant? Yes No *Are you nursing? Yes No

I understand the above information is necessary to provide my dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

Patient Signature:_____ Date:_____

Parent or Responsible Party Signature:_____ Relationship to Patient:_____

Dentist's Signature: _____ Date:_____