MEDICAL HEALTH HISTORY

Dr. William W. Calhoun

Name ______________________ SS# ______________ Date of Birth _____ / _____ / _____

Address ______________________________________ Gender: ❑ Male ❑ Female

City ____________________ State ________ Zip ________ Employer ______________

Telephone (Home) __________ (Cell) __________ (Work) __________ Occupation ______________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Spouse's Name ________________ Spouse's SS# ______________ Date of Birth __________

Spouse's Employer __________________________ Spouse's Work Telephone ______________

Name of Nearest Relative (Emergency) ____________________ Emergency Telephone ______________

Whom may we thank for referring you? ______________________________________

MEDICAL HISTORY

Height ______ Weight ______ Age ______

Date of last dental examination __________________ Date of last dental x-ray __________________

Name of your medical doctor __________________ Date of last complete medical exam ______________

Are you under medical treatment now? ______ Why? ______________________________

What pills or medications are you presently taking? ______________________________

____

For what purpose? ____

____

Have you had major surgery in the last two years? ______ What for? ______________________

Do you clench or grind your teeth? ______________________________________

Are you presently in dental pain? ______________________________________

Is any part of your mouth sensitive to temperature, pressure, or food or drink? What? ______________

Do you currently take herbs / vitamins? Which ones? ______________________________

Do you have headaches? How often? ______________________________________

Have you had any pains in the chest or shortness of breath? ______________________________

Are you handicapped or disabled? ______________________________________

Have you ever had any type of radiation therapy (other than diagnostic)? ______________________

Do you smoke or use chewing tobacco? ______________________________________

Are you susceptible to latex allergy? ______________________________________

Have you ever take Fen-Phen? ______________________________________

Are you pregnant? ______________________________________

Are you allergic to:

	✓Yes	✓No	
Drugs	❑	❑	What? ______
Dental anesthetic	❑	❑	What? ______
Metals	❑	❑	What? ______
Other material	❑	❑	What? ______
Foods or insects	❑	❑	What? ______

Do you have or have you ever had any of the following:

	✓Yes	✓No
Abnormal blood pressure	❑	❑
Arthritis or rheumatism	❑	❑
Artificial joints	❑	❑
Asthma or hay fever	❑	❑
Blood disease or anemia	❑	❑
Chemotherapy	❑	❑
Chronic cough	❑	❑
Cold sores or fever blisters	❑	❑
Congenital heart lesions	❑	❑
Diabetes	❑	❑
Epilepsy	❑	❑
Excessive urination or thirst	❑	❑
Fainting spells	❑	❑
Frequent canker sores	❑	❑
Glaucoma	❑	❑
Head injury	❑	❑
Heart disease	❑	❑
Heart murmur	❑	❑

	✓Yes	✓No
Heart pacemaker	❑	❑
Heart prolapse mitral valve	❑	❑
Hepatitis	❑	❑
HIV / ARC / AIDS	❑	❑
Jaundice	❑	❑
Kidney disorder	❑	❑
Leukemia	❑	❑
Multiple Sclerosis	❑	❑
Parkinsons	❑	❑
Prolonged bleeding	❑	❑
Psychiatric treatment	❑	❑
Rheumatic fever	❑	❑
Sinus trouble	❑	❑
Stroke	❑	❑
Thyroid condition	❑	❑
Tuberculosis or lung disease	❑	❑
Tumors or growths	❑	❑
Ulcers	❑	❑

Tell your health care professional about all other medicines you are taking, including non-prescription medicines, nutritional supplements, or herbal products. Also tell your health care professional if you are a frequent user of drinks with caffeine or alcohol, if you smoke, or if you use illegal drugs. These may affect the way your medicine works.

Any other medical or health concerns that the dentist should be aware of: ______________________

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Signature ______________________ Date ____________ Date ____________