HIGHLAND
DENTAL

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Medical History

Patient Name: _____ Date: _____

Are You Allergic To Any Of The Below?
Check All That Apply:

- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa

List Any Other Allergies: _____

Check All That Apply:

- ☐ Abnormal (High/Low) Blood Pressure
- ☐ AIDS / HIV
- ☐ Anemia / Bleeding Problems
- ☐ Artificial Heart Valves
- ☐ Blood Disease
- ☐ Congenital Heart Lesions
- ☐ Heart Problems
- ☐ Pacemaker
- ☐ Epilepsy
- ☐ Fainting / Dizziness
- ☐ Headaches (Frequent)
- ☐ Arthritis / Rheumatism / Gout
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Herpes
- ☐ Kidney Disease
- ☐ Radiation Treatment (X-Ray/Cobalt)
- ☐ Shortness of Breath (Breathing Problems)
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumor / growth on head / neck
- ☐ Ulcer
- ☐ Liver Disease
- ☐ Nervous Problems
- ☐ Psychiatric Care

List Any Other Medical Issues You Have: _____

List Any Serious Illnesses / Surgeries / Hospitalizations: _____

List Any Medications You Are Taking: _____

Do you smoke? ☐ YES ☐ NO

Pregnant: ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

Nursing: ☐ YES ☐ NO

Physician Name: _____

Physician Phone Number: _____

Has the patient ever been hospitalized? ☐ YES ☐ NO

Please state the reason for hospitalization:

_____

_____

_____

Is the patient physically, mentally or emotionally impaired? ☐ YES ☐ NO

Describe the patient's current physical health: ☐ Poor ☐ Fair ☐ Good

Signature: _____ **Date:** _____