PAPPERT AND KIRK
FAMILY DENTISTRY

Welcome! So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health.

Please complete this medical history form. This information is, of course confidential.

MEDICAL HISTORY

Name: ______________________________ Birthdate __________ Gender __________

Premed ______________ BP ____________________ Date of last physical __________

Name and Number of physician ______________________________

Please describe any major illness or hospitalizations in the last year.

Please list any medications/drugs/pills you are currently taking.

Please check if you are allergic (or have had adverse reactions) to:

❒ Latex ❒ Aspirin ❒ Codeine ❒ Local Anesthetic ❒ Sulfa ❒ Penicillin
❒ Other Antibiotics ❒ Other ❒ None

In case of an emergency, are there any special instructions you would like us to know?

Please check if you have, or have ever had any of the following:

Respiratory:
❒ Sinus Problems ❒ Asthma ❒ Allergies/Hives ❒ Tuberculosis (TB) ❒ Emphysema/Bronchitis

Cardiovascular:
❒ Heart Disease ❒ Heart Attack or Failure ❒ Angina ❒ High Cholesterol
❒ Stroke ❒ Mitral Valve Prolapse ❒ Aneurysm ❒ Heart Problems at Birth
❒ Heart Murmur ❒ High Blood Pressure ❒ Pacemaker/Defibrillator
❒ Damaged/Artificial Heart Valves ❒ Arrhythmias/Palpitations
❒ Rheumatic Fever/Rheumatic Heart Disease ❒ Heart Surgery/Transplant

Hematologic:
❒ Blood Transfusion ❒ Sickle Cell/Abnormal Bleeding ❒ Anemia ❒ Leukemia ❒ Hemophilia

Urogenital:
❒ Kidney/Bladder Problem ❒ Sexually Transmitted Disease ❒ HIV/AIDS
❒ Hepatitis (type in notes) Type __________

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