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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Endocrine:
❒ Diabetes ❒ Thyroid Disease

Gastrointestinal:
❒ Stomach/Intestinal Ulcers ❒ Gastritis ❒ Colitis ❒ Liver Disease ❒ GERD

Dermal/Muscular/Skeletal:
❒ Skin Rash/Disease ❒ Arthritis ❒ Dark Moles ❒ Artificial Joint
❒ Discolored Areas in Mouth

Neural/Sensory:
❒ Contact Lenses ❒ Glaucoma ❒ Severe/Frequent Headaches ❒ Dementia
❒ Fainting/Dizziness ❒ Depression ❒ Psychiatric Treatment ❒ Fibromyalgia
❒ Epilepsy/Seizures/Convulsions ❒ Nervousness/Phobias/Anxiety

Other Conditions:
❒ Tumor/Cancer ❒ X-Ray Treatment to Head/Neck ❒ Chemotherapy
❒ Sleep Apnea ❒ Hearing Problems

WOMEN: ❒ Are you pregnant? ❒ Breast feeding ❒ Do you take birth control medications?

If you use (or have used) any of the following, please describe:
Tobacco Product (type, frequency, amount, how long?)

Alcohol (frequency, amount, how long?)
Are you currently, or have you ever been in recovery for drug/alcohol addiction? ❒ yes

Is there any other information regarding medications, drugs, or health conditions we should know?

Drs Comments

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you. I will notify my dentist of any changes in my health or medication.

Signature of Patient or Patients Guardian Date