Mill Creek Dental
Health History

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Being treated for a medical condition
- ❑ Have/had any serious illness or operation? _____
- ❑ Smoke or use chewing tobacco _____ frequency
- ❑ Recreational drug use _____ frequency
- ❑ Aids/HIV
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Head Injuries
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Mitral Valve Prolapse
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Other: _____

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin/Acetaminophen/ibuprofen
- ❑ Metals
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Antibiotics prior to dental appointments?
- ❑ Other:_____
  _____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Nursing
- ❑ Taking hormones or contraceptives

Name of your physician:_____Date of last visit: _____

Do you have any disease, condition, or problem not listed above?_____

Please list all medications (including supplements) _____

_____

_____

Please add anything else you would like us to know about:_____

_____

Signature of patient (or parent) _____ Date_____