Medical History Form

Columbia City Dental

Name: _____

Please check the box for any condition you have had in the past or have now.

- ☐ Heart Problem
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ Bleeding disorder
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Headaches
- ☐ Fainting/Dizzy spells
- ☐ Stroke
- ☐ Epilepsy or Seizures
- ☐ Psychiatric treatment
- ☐ Anxiety/Phobias
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Hay fever/Allergies
- ☐ Sinus trouble
- ☐ Asthma
- ☐ Breathing difficulties
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Joint replacement
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cortisone or steroid use
- ☐ Kidney/Bladder problem
- ☐ Dialysis
- ☐ Organ transplant
- ☐ STD
- ☐ HIV
- ☐ Drug or alcohol addiction
- ☐ Tumor or Cancer
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ Sleep disorder

Any disease, problem, or condition not listed?

If yes, please list:_____

_____

Who is your physician?

Name _____

Address _____

Phone _____

List any medications or supplements you are currently taking: _____

_____

_____

_____

_____

Do you have any reactions or allergies to drugs or medications? No _____ Yes _____

If yes, please explain: _____

_____

_____

For women:

Are you pregnant or possibly pregnant?

No _____ Yes _____

If yes, due date: _____

Date _____

_____

Patient, Parent, or Guardian Signature

_____

Dentist Signature