

75 East 1400 South Garland, UT 84312

435.257.7016

MEDICAL HISTORY: Please Circle

Are you under a physician's care now? Why? Who? _____ Phone# _____ Yes No

Have you ever been hospitalized or had a major operation? Discuss _____ Yes No

Have you ever had a serious injury to the head or neck? Discuss _____ Yes No

Are you taking any medications, pills or drugs? What? _____ Yes No

Are you on a special diet? Discuss _____ Yes No

Are you allergic to any medications or substances? Please check box below _____ Yes No

Aspirin Penicillin Codeine Acrylic Metal Latex rubber Other _____

Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives

If yes to any of the starred* conditions, please call prior to your appointment... Pre-medication may be required.

	Yes	No		Yes	No
Heart Trouble/Disease			Bruise Easily		
Heart Murmur*			Anemia		
Irregular Heartbeat			Excessive Bleeding		
Angina / Chest Pain			Sickle Cell Disease		
Heart Attack/ Failure			Hemophilia		
Congenital Heart disorder			Leukemia		
Mitral Valve Prolapse*			Recent Blood Transfusion		
Scarlet Fever			Swelling of Limbs		
Rheumatic Fever*			Lung Disease		
Artificial Heart Valve*			Breathing Problem		
Heart Pace Maker*			Shortness of Breath		
Heart Surgery*			Frequent Cough		
High Blood Pressure			Hay Fever		
Low Blood Pressure			Sinus Trouble		
Blood Disease			Asthma		
Yellow Jaundice			Cold Sores		
Kidney Problems			Fever Blisters		
Renal Dialysis			Herpes		
Venereal Disease			Stroke		
AIDS			Convulsions		
HIV Positive			Epilepsy or Seizures		
Genital Herpes			Fainting or Dizziness		
Drug Addiction			Nervousness		
Allergies (Medicines)			Psychiatric Care		
Allergies (Pollen or Dust)			Hives or Rash		
			Emphysema		
			Tuberculosis		
			Cancer		
			Radiation Treatment		
			Chemotherapy		
			Stomach/ Intestinal Disease		
			Ulcers		
			Recent Weight Loss		
			Frequent Diarrhea		
			Diabetes		
			Excessive Thirst		
			Hypoglycemia		
			Liver Disease		
			Hepatitis A (infectious)		
			Hepatitis B or C		
			Thyroid Disease		
			Parathyroid disease		
			Arthritis/ Gout		
			Rheumatism		
			Pain in Jaw Joints		
			Cortisone Medicine		
			Glaucoma		
			Tumors or Growths		
			Alzheimer's Disease		

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and the staff at the next appointment without fail.

X _____ **Date** _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ **Date** _____

Significant Findings _____
