MEDICAL HEALTH HISTORY

BAY SHORE DENTAL
316 E. Silver Spring Dr. Ste 243
Whitefish Bay, WI 53217

Name_____ Birth Date_____Age _____
Emergency Contact _____ Relationship_____ Phone _____
Physician's Name_____ Location_____ Phone _____
Last Physical Exam?_ _____ Blood Pressure_____

Yes □ No □ Have you had any medical treatment or physician visit in the past year?
If yes, describe_____

Yes □ No □ Past Surgeries? If yes, describe_____

List prescription and non-prescription medications- Examples: ASPIRIN/BLOOD THINNERS, inhaler, Fosamax/Boniva, birth control/hormones, cough syrup, diet drugs-_____
_____

PLEASE INDICATE IF YOU HAVE, OR HAVE NOT HAD, ANY OF THE FOLLOWING:

YES	NO		YES	NO	
□	□	Arthritis	□	□	Osteoporosis-Boniva/Fosamax
□	□	Anemia/Sickle Cell Disease	□	□	Anorexia/Bulimia
□	□	Hemophilia/Bleeding/Blood Disorder	□	□	Thyroid Condition
□	□	High or Low Blood Pressure (circle)	□	□	Herpes II or STD
□	□	Epilepsy/Seizures	□	□	Hip/Joint Replacement
□	□	Asthma	□	□	AIDS/HIV
□	□	Fainting Spells	□	□	Radiation/Chemo Therapy
□	□	Diabetes	□	□	Ear Infections
□	□	Hepatitis	□	□	Chronic Sinus
□	□	Tuberculosis	□	□	Allergies- check all that apply:
□	□	Aspirin Therapy/Blood Thinners			□ Aspirin
□	□	Abnormal Bleeding			□ Hay fever/Seasonal
□	□	Heart Murmur/Mitral Valve Prolapse/Rheumatic Fever			□ Anesthetic
□	□	Heart Disease/Surgery			□ Antibiotics
□	□	Pacemaker			□ Codeine
□	□	Kidney Disorder			□ Latex
□	□	Jaw Pain/ TMJD			□ Metal
□	□	Headaches/Migraines			□ Food
□	□	Acid Reflux/GURD			□ Medications- If yes, list:
□	□	Ulcers			_____
					□ Other_____

□ □ Women: Are you pregnant? If yes, anticipated delivery date_____
□ □ Have you been told that you need antibiotic pre-medication before Dental treatment?
□ □ Have you tested positive for AIDS or AIDS related virus?
□ □ Do you smoke? If yes, how many packs per day?_____
□ □ Do you have/had any other medical condition not mentioned above? If yes, describe below:
_____

Signature_____Date_____

Reviewed by_____