CHAGRIN HIGHLANDS DENTAL GROUP

Medical History – Please tell us about your past & present medical condition

CURRENT PHYSICIAN INFORMATION

Do you have a personal physician? ☐ Yes ☐ No

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Physician's Name: _____ Physician's Phone: _____ Date of last visit: _____ (mm/yyyy)

TOBACCO USE

Do you use tobacco in any form? ☐ No ☐ Yes _____ and for how long: _____
(What type of tobacco product: / Months or Years)

PROSTHETIC JOINTS

Have you had any prosthetic joints such as **KNEES or HIPS** placed in your body? ☐ No ☐ Yes _____ _____
(What type of joint / Date (mm/yy))

HISTORY OF SURGERIES

Have you ever had any surgical procedures? ☐ No ☐ Yes _____
(List ALL surgical procedures)

CURRENT MEDICATIONS

Are you currently taking any medications? ☐ No ☐ Yes (please list ALL medications below – including non-prescription and herbals)

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

CURRENT ALLERGIES

Please list any medication (ie: penicillin, sulfa, codeine), material (ie: latex, jewelry, metals) and general allergies below:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

HISTORY OF MEDICAL CONDITIONS _____
(List any medical condition NOT indicated below)

	Y	N		Y	N		Y	N		Y	N
Abnormal Bleeding			Congenital Heart Defect			Hepatitis (Type:)			Rheumatic Fever		
Alcohol Addiction			Diabetes			Kidney Disease			Sinus Problems		
Anemia			Difficulty Breathing			Liver Disease			STD		
Angina Pectoris			Drug Addiction			Lung Disease			Sickle Cell Disease		
Arthritis			Emphysema			Mitral Valve Prolapse			Stroke		
Artificial Heart Valve			Epilepsy / Seizures			Osteoporosis			Thyroid Disease		
Aspirin / Anticoagulant			Frequent Headaches			Pace Maker			Tuberculosis (TB)		
Asthma			Glaucoma			Psychiatric Problems			Ulcers		
Blood Pressure – High			HIV Positive / AIDS			Radiation Treatment					
Blood Pressure – Low			Heart Attack			**If female, please answer the following section:**					
Blood Transfusion			Heart Murmur			Are you pregnant? ☐ Yes _____ weeks ☐ No ☐ Maybe					
Cancer			Heart Surgery			Are you nursing? ☐ Yes ☐ No					
Chemotherapy			Hemophilia			Are you taking birth control pills? ☐ Yes ☐ No					

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Patient Name (print) _____

Patient Signature _____ Date _____