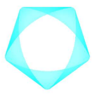
PATIENT INFORMATION



CONVERGENT
DENTISTRY

MEDICAL HEALTH HISTORY

Please check if you have/had:	Yes	No
Allergies, hay fever, sinusitis	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Required Hospitalization	☐	☐
Have you used steroids	☐	☐
Date of last episode ___________________		
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Abnormal bleeding with surgery	☐	☐
Blood disease (anemia) or clotting disorders	☐	☐
Blood pressure High or Low	☐	☐
Easy bruising	☐	☐
Ever require a blood transfusion	☐	☐
Frequent nosebleeds	☐	☐
Recast Transfusions	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Emphysema	☐	☐
Epilepsy or seizures	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Head injury history	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis type ___________	☐	☐
HIV– positive/AIDS	☐	☐
Herpes or other STD	☐	☐
Immune deficiency	☐	☐
Kidney disease	☐	☐
Mitral valve prolapsed	☐	☐
Osteoporosis	☐	☐
Ostopenia	☐	☐
Pacemaker	☐	☐

	Yes	No
Radiation treatments	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus problems	☐	☐
Sickle cell anemia	☐	☐
Skin rash	☐	☐
Slow healing wounds	☐	☐
Stroke(s)	☐	☐
Swelling of feet or ankles	☐	☐
Thyroid problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal disease	☐	☐
Weight gain or loss, unexplained	☐	☐
Do you have any disease, condition, or problem not listed previously that you feel we should know about? If so, please describe: _________________	☐	☐

____

During the past 12 months, have you taken any of the following?	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drugs/supplements	☐	☐

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant? If so, expected delivery date: ___________________	☐	☐
Are you nursing?	☐	☐
Have you reached menopause? If so, do you have any symptoms? ______________ ____	☐	☐

Patient/Parent Signature: **X** ______________________________

Date: ________________ Dentist Initials: _________________