BURTCH DENTAL

MEDICAL HISTORY

Name:_____ Date of Birth:_____
Physician:_____ Pharmacy:_____

Allergies:_____

List any medications, supplements and or vitamins taken within the last two years:

Drug	Purpose	Drug	Purpose
_____		_____	
_____		_____	

Please <u>circle</u> if you have had any of the following:

- ☐ Heart attack
- ☐ Coronary artery stent
- ☐ Artificial heart valve or repaired heart defect
- ☐ Pacemaker
- ☐ Heart transplant
- ☐ High or low blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Cancer - chemotherapy or radiation
- ☐ Artificial Prosthesis
- ☐ Anemia or other blood disorder
- ☐ Asthma or Respiratory disorder/ COPD
- ☐ Emphysema/ Tuberculosis
- ☐ Sinus problems
- ☐ Kidney disease or liver disease
- ☐ Autoimmune disease
- ☐ Diabetes - Type I or 2
- ☐ Stomach or digestive disorders
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Glaucoma or contact lenses
- ☐ Epilepsy/ Seizures
- ☐ HIV/ AIDS/ Hepatitis / HPV
- ☐ Hearing impaired
- ☐ Head or neck injuries
- ☐ Headaches/ Migraines
- ☐ Viral infections and cold sores
- ☐ History of mental illness
- ☐ Prolonged bleeding due to a slight cut
- ☐ Do you smoke/ vape/ cannabis
- ☐ Drug or alcohol dependency
- ☐ Pregnant
- ☐ Hospitalized in the past 5 years

Any other diseases, conditions or problems not listed above: _____
_____

Dental History:

Date of your last visit to a dentist:_____ Name of previous dentist:_____
What concerns do you have about your teeth/oral health:_____
_____
_____

Patient Signature:_____ Date:_____

Provider Signature:_____ Date:_____