DENTAL SPECIALISTS
OF MILWAUKEE

HEALTH HISTORY

Patient Name_____ Date of Birth_____

General Dentist_____ Last Visit_____ Physician's Name_____ Ph #_____

Are you being treated by a physician? YES NO

HAVE YOU HAD ANY ILL EFFECTS FROM ANY OF THE FOLLOWING?

Local anesthetic……yes no
Penicillin……...yes no
Erythromycin……yes no
Amoxicillin……...yes no
Aspirin……..yes no
Codeine……yes no
Sulfa……yes no
Latex……yes no
Any other drug…….yes no
Please list_____

Are you taking any medications to thin your blood?…….yes no
Have you had any problem with abnormal bleeding?……yes no
Are you receiving any form of treatment for cancer?.....yes no
-Radiation treatment to your head or neck?.....yes no
-Chemotherapy?. ……...yes no
Do you wear a pacemaker?.....yes no
Have you been tested for HIV?.....yes no
-If so, were the results……positive negative
Have you had surgery in the past 2 years?.....yes no
-If yes, please describe_____
Do you have any artificial joints?.....yes no
-If so, when were they placed?_____
Are you required to take a **pre-med** prior to any dental appointments? yes no
If you smoke, how many packs a day?_____
Females: Are you pregnant?_____ Due date_____

HAVE YOU EVER HAD…

Heart trouble……..yes no
Heart surgery…….yes no
Heart valve problems…….yes no
History of heart murmur…yes no
Rheumatic fever…….yes no
Hepatitis…….yes no
Tuberculosis……..…..yes no
Arthritis……...yes no
Epilepsy or seizures……yes no
Diabetes……..yes no
Tumor or malignant growth…yes no
Kidney or liver disease……...yes no
High/Low blood pressure……High Low Normal

Patient signature_____
Date_____

FOR OFFICE USE ONLY

DATE	COMMENTS

DENTAL SPECIALISTS
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LIST OF MEDICATIONS PHARMACY_____PH#_____

1		4		7	
2		5		8	
3		6		9	