Medical History

Patient Name:_____ Date: _____/_____/_____

Have you ever had any of the following? (check boxes that apply):

- ☐ Presently under a physician's care
- ☐ Hospitalization in the last 5 years
- ☐ Recent illness
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Irregular heartbeat
- ☐ Artificial heart valve
- ☐ Pacemaker
- ☐ Stroke
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Skeletal disorder (i.e., osteoperosis, arthritis)
- ☐ Artificial joint (i.e., hip, knee)
- ☐ Diabetes
- ☐ Bleeding disorder (i.e., hemophilia, anemia)
- ☐ Blood transfusions
- ☐ AIDS / HIV
- ☐ Sexually transmitted diseases
- ☐ Cold sores / fever blisters
- ☐ Liver disorders (i.e., hepatitis, cirrhosis)
- ☐ Respiratory disorders
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Hay fever / allergies / sinusitis
- ☐ Kidney disorder
- ☐ Digestive disorder (i.e., ulcers, reflux)
- ☐ Thyroid disorder
- ☐ Epilepsy / seizures
- ☐ Cancer
- ☐ Chemotherapy treatment
- ☐ Radiation treatment
- ☐ Steroid therapy
- ☐ Pregnant / breast feeding (currently)
- ☐ Birth control
- ☐ Hormone replacement
- ☐ Drug Addiction
- ☐ Psychiatric disorder (i.e., anxiety, depression)
- ☐ Developmental disorder (i.e., autism, ADHD)

Any serious illness not listed above? Explain: _____

_____

Allergies: _____

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_____

Medications: _____

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Dr. Hart's Notes:_____

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I certify that the above information is accurate and complete to the best of my knowledge and is only for use in my treatment. I will not hold Kai D. Hart, DMD, Hart Dental Care, or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient (Parent/Guardian if under 18) Date