Medical Health History

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REVEAL DENTAL
COSMETIC, FAMILY & IMPLANT DENTISTRY

Medical Health History

Patient's First Name *

Patient's Last Name *

Patient's Date of Birth *
MM/dd/yyyy

Today's Date
07/08/2024

Address *

City *

State *
Please sel...

Zip Code *
_____

Email *

Phone *
(___) ___-____

Please Check Yes (Y) or No (N) for those that apply to you

Anemia * ○ Yes ○ No

Arthritis * ○ Yes ○ No

Artificial Heart Valve * ○ Yes ○ No

Artificial Joints * ○ Yes ○ No

Asthma * ○ Yes ○ No

Blood Disease * ○ Yes ○ No

Bruise Easily * ○ Yes ○ No

Cancer * ○ Yes ○ No

Chemotherapy * ○ Yes ○ No

Diabetes * ○ Yes ○ No

Dizziness * ○ Yes ○ No

Drug Addiction * ○ Yes ○ No

Emphysema * ○ Yes ○ No

Excessive Bleeding * ○ Yes ○ No

Fainting * ○ Yes ○ No

Glaucoma * ○ Yes ○ No

Heart Conditions * ○ Yes ○ No

Heart Lesions * ○ Yes ○ No

Heart Murmur * ○ Yes ○ No

Heart Surgery * ○ Yes ○ No

Hepatitis * ○ Yes ○ No

High Blood Pressure * ○ Yes ○ No

HIV Positive * ○ Yes ○ No

Jaundice * ○ Yes ○ No

Kidney Disease * ○ Yes ○ No

Liver Disease * ○ Yes ○ No

Low Blood Pressure * ○ Yes ○ No

Mitral Valve Prolapse * ○ Yes ○ No

Nervousness/Depression * ○ Yes ○ No

Pacemaker * ○ Yes ○ No

Periodontal Disease * ○ Yes ○ No

Radiation * ○ Yes ○ No

Respiratory Problems * ○ Yes ○ No

Rheumatic Fever * ○ Yes ○ No

Rheumatism * ○ Yes ○ No

Scarlet Fever * ○ Yes ○ No

Seizures * ○ Yes ○ No

Stomach Problems * ○ Yes ○ No

Stroke * ○ Yes ○ No

Thyroid Disease * ○ Yes ○ No

Tuberculosis * ○ Yes ○ No

Ulcers * ○ Yes ○ No

STD * ○ Yes ○ No

Other ○ Yes ○ No

Women Only

Birth Control ○ Yes ○ No

Nursing ○ Yes ○ No

Pregnant ○ Yes ○ No

Do you have any of the following drug allergies?

Aspirin * ○ Yes ○ No

Erythromycin * ○ Yes ○ No

Nitrous Oxide * ○ Yes ○ No

Penicillin * ○ Yes ○ No

Codeine * ○ Yes ○ No

Latex * ○ Yes ○ No

Sulfa * ○ Yes ○ No

Antibiotics * ○ Yes ○ No

Darvon * ○ Yes ○ No

Anesthetic * ○ Yes ○ No

Percodan * ○ Yes ○ No

Valium * ○ Yes ○ No

Please list other allergies:

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Please Check Yes (Y) or No (N) if you have taken any of the following drugs at any time:

Fosamax * ○ Yes ○ No

Didronel * ○ Yes ○ No

Zometa * ○ Yes ○ No

Boniva * ○ Yes ○ No

Aredia * ○ Yes ○ No

Actonel * ○ Yes ○ No

Skelid * ○ Yes ○ No

Bisphosphonates * ○ Yes ○ No

Please list ALL medications you currently take: (Prescription & Over-the-Counter. Attach List if Needed) *

Please list all surgeries with approximated dates:

Please list any other medical conditions: *

If under a physician's care, please explain:

Physician's Name

Physician's Phone (___) ___-____

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify Reveal Dental of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold Reveal Dental or its employees liable in the event of death or injury.

Patient or Guardian Signature *

Date 07/08/2024

Dentist Signature

Date

07/08/2024 ~