MICHAEL DYER DMD
FAMILY AND COSMETIC DENTISTRY

Patient Medical Health History Form 2023

ARE YOU ALLERGIC TO, OR HAVE YOU EVER HAD A REACTION TO THE FOLLOWING:					
Aspirin:	YES	NO	Penicillin or Other Antibiotics:	YES	NO
Codeine or Narcotics:	YES	NO			
Latex:	YES	NO	Sodium Pentothal, Valium, other Tranquilize	YES	NO
Local Anesthetics (numbing Meds):	YES	NO	Sulfa Drugs:	YES	NO
Painkillers and Other Analgesics:	YES	NO	Additional Allergies:	YES	NO
HAVE YOU EVER HAD...OR DO YOU CURRENTLY HAVE...ANY OF THE FOLLOWING:					
Anemia:	YES	NO	Heart - Congenital Disease:	YES	NO
Alcoholism or History of Alcohol Abuse:	YES	NO	Heart - Atrial Fibrillation	YES	NO
Angina/Chest Pain:	YES	NO	Heart - Surgery:	YES	NO
Arthritis, Swollen Joints or Joint Disease:	YES	NO	Heart - Valve Replacement:	YES	NO
Asthma:	YES	NO	Hepatitis - What Type:	YES	NO
Birth Control Pills (Women Only)	YES	NO	Joint Replacement - Date:	YES	NO
Blood Disorder/Hemophilia/Bleeding:	YES	NO	Kidney Disease:	YES	NO
Blood Pressure - High or Low (If Yes, Circle One)	YES	NO	Liver Disease:	YES	NO
Cancer - What Type:	YES	NO	Lung Disease or Disorder:	YES	NO
Compromised Immune System:	YES	NO	Mental Health Disorder:	YES	NO
Contagious Diseases - Type:	YES	NO	Osteoporosis/Osteopenia:	YES	NO
Dementia/Alzheimer's:	YES	NO	Pacemaker - Date:	YES	NO
Diabetes - High or Low Blood Sugar (If Yes, Circle One)	YES	NO	Radiation Treatment:	YES	NO
Difficulty Breathing /Other Lung Trouble:	YES	NO	Snoring/Sleep Apnea:	YES	NO
Drug Abuse - Current or Previous History:	YES	NO	HIV/AIDS: What Type?	YES	NO
Emphysema	YES	NO	STD: What type?	YES	NO
Epilepsy/Seizures:	YES	NO	Stroke - Date:	YES	NO
Eye Surgery/ Glaucoma:	YES	NO	Tobacco Products - Packs per Day:	YES	NO
Fainting Dizzy Spells:	YES	NO	Tobacco Chewing:	YES	NO
Head Injury:	YES	NO	Thyroid Disease:	YES	NO
Heart Attack - Date:	YES	NO	Tuberculosis:	YES	NO
Other Conditions Not Listed: See back of this sheet			Women only: Pregnant/Nursing/Menopause	Circle One	

Patient Name: ______________________ Date of Birth: ______________________
(Please Print) (MM/DD/YYYY)

Patient Signature: ______________________ Date: ______________________

*****PLEASE CONTINUE TO THE BACK SIDE*****

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Please answer the following questions:	Circle One		Comments	
DENTAL HEALTH				
Are you happy with the appearance of your teeth:	YES	NO		
Would you like information to make them whiter:	YES	NO		
Do you have any dental concerns or problems:	YES	NO		
Do you clench or grind your teeth:	YES	NO		
Have you ever had problems with dental treatment:	YES	NO		
Have you ever had an unusual reaction to dental anesthetics:	YES	NO		
Have you ever been premedicated prior to dental visits:	YES	NO		
Are you *currently* taking premedications for dental procedures:	YES	NO		
What is your preferred pharmacy?				
MEDICAL HEALTH				
Are you currently under the care of a physician:	YES	NO	Reason:	
Have you ever seen a periodontist/gum specialist?	YES	NO	Reason:	
Name of Physician:			Number:	
Name of Cardiologist:			Number:	
Name of Periodontist:			Number:	
Have you ever had major operations, illness or been hospitalized:	YES	NO	If yes, list:	
Have you ever been treated with steroid (cortisone) therapy:	YES	NO		

Please print medications or provide medication list	
Medications	Dosage

Additional Notes:

OFFICE USE ONLY BELOW THIS POINT

Base Line B/P _________________________ / Pulse _________________________

RDH/RDA Initials:_______________

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