Glenwood Dental
General & Cosmetic Dentistry

Medical History Continued ...

Do you have, or have you ever had, any of the following:

Rheumatic heart disease or rheumatic fever	YES	NO	Diabetes	YES	NO
Scarlet Fever	YES	NO	AIDS or HIV Infection	YES	NO
Heart defect	YES	NO	Sinus Trouble	YES	NO
Heart murmur	YES	NO	Thyroid Problems	YES	NO
❑ Heart trouble ❑ Heart attack ❑ Angina	YES	NO	Allergies	YES	NO
Do you have pain in your chest upon exertion	YES	NO	Arthritis	YES	NO
Are you ever short of breath after mild exercise	YES	NO	Rheumatism	YES	NO
Do your ankles swell	YES	NO	❑ Joint Replacement ❑ Implant	YES	NO
Do you get short of breath when you lie down	YES	NO	Stomach Ulcer	YES	NO
Do you require extra pillows when you sleep	YES	NO	Kidney Trouble	YES	NO
Pacemaker	YES	NO	Tuberculosis	YES	NO
Heart Surgery	YES	NO	Persistent Cough	YES	NO
High Blood Pressure	YES	NO	Cough that produces blood	YES	NO
Low Blood Pressure	YES	NO	Cancer	YES	NO
Hepatitis A B C	YES	NO	Sexually Transmitted Disease	YES	NO
Jaundice	YES	NO	Epilepsy	YES	NO
Liver Disease	YES	NO	Anemia	YES	NO
Stroke	YES	NO	Leukemia	YES	NO
Lung or Breathing Problems	YES	NO	Eating Disorder	YES	NO
Asthma	YES	NO	**Women Only:**		
Hay Fever	YES	NO	Are you pregnant or think you may be	YES	NO
Hives or Skin Rash	YES	NO	Are you nursing	YES	NO
Fainting Spells or Seizures	YES	NO	Are you taking birth control pills	YES	NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian _____ ***Date*** _____

FOR COMPLETION BY DR. OH & STAFF

Summary of Dental History: _____

Summary of Medical History: _____

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