



Hightower dental concepts

Compassionate Family Dentistry

Updated Medical Health History

(Print)Name _____

(Yes/No) Are you allergic to any drugs or medications? If yes, please List _____

(Yes/No) Have you had any knee or joint replacement surgeries? If yes, please list with date:

(Yes/No) Any heart surgeries? If yes, please list with date: _____

(Yes/No) High blood pressure? If yes, please list medication: _____

(Yes/No) A heart ailment, including mitral valve prolapse or heart murmur? _____

(Yes/No) Do you have Diabetes?

(Yes/No) Do you have Rheumatic fever?

(Yes/No) Do you have HIV or AIDS? If yes, please list medication: _____

(Yes/No) Do you have Hepatitis? If yes, please list type: _____

(Yes/No) Have you ever had any radiation treatment?

(Yes/No) Do you have epilepsy, convulsions, or seizures?

(Yes/No) Do you have any pain in or near your ears?

(Yes/No) Are you pregnant? If yes, how many months? _____.

Are there any other conditions we should be aware of? _____

Are you presently taking drugs or medications not listed above for any other medical condition? If yes, please list: _____

Is there anything you would like to change about your teeth since the last visit?

Do you want whiter teeth? _____

Patient Signature: _____

Date: _____

Any change of Address or Phone number?
