MEDICAL HISTORY

CHECK ALL THAT APPLY TO YOU

Anemia __
Artificial Heart Valve __
Artificial Heart Valve __
Artificial Joint(s) __ which one(s)? _____
Year of surgery(s): _____
Asthma __
Auto-Immune Disorders __
Type: _____
Blood Disease __
Type: _____
Bruise Easily __
Cancer __
Canker Sores __
Chemo/Radiation __
Clinical Depression __
Diabetes __
Emphysema __
Excessive Bleeding __
Fever Blisters __
Glaucoma __
Heart Attack __
Heart Surgery __
Hepatitis A __ B __ C __
Herpes __
High Blood Pressure __
HIV Positive __
Kidney Issues __
Liver Disease __
Low Blood Pressure __
Osteoporosis __ Injections? __
Pacemaker __
Panic Attacks __
Pregnant __ How far? _____
Respiratory Problems __
Seizures __
Smoke/Vape __
Stomach Issues __
Stroke __
Thyroid __
Tuberculosis __
Other _____
_____
Aspirin Daily _____ mg
Blood Thinner _____

ARE YOU ALLERGIC TO: PENICILLIN __ CODEINE __ ASPIRIN __ LATEX __
LIST OTHER ALLERGIES: _____

ANY PROBLEMS RELATED TO **DENTAL ANESTHETIC?** _____

PREVIOUS DENTIST: _____ CURRENT XRAYS? _____
IF **YES**, **PLEASE REQUEST THEY BE E-MAILED TO OUR OFFICE: emily@sullivantdentistry.com**

PLEASE LIST ALL MEDICATIONS: _____
_____
_____

WHO IS YOUR MEDICAL DR: _____ PHARMACY: _____

*THE ABOVE INFORMATION IS CURRENT AND ACCURATE, **I WILL** MAKE THIS OFFICE AWARE OF **ANY CHANGES BEFORE FUTURE APPOINTMENTS**.*

SIGNATURE: _____ DATE: _____