MIDTOWN
DENTAL
WELLNESS

MEDICAL HISTORY FORM

	Yes	No	
Allergies to Anesthetics	____	____	
Allergies to any Medications	____	____	If so, what?_____
Any heart ailments/murmurs	____	____	
High or low blood pressure	____	____	
Mitral Valve Prolapse	____	____	
Neurological Disorders	____	____	
Cancer history	____	____	
Radiation/Bisphosphonates	____	____	
Excessive bleeding from cuts	____	____	
Anemia	____	____	
Asthma	____	____	
Diabetes/kidney problems	____	____	
Liver problems/hepatitis	____	____	
Tuberculosis	____	____	
Psychiatric care	____	____	
Sinus problems	____	____	
Artificial joint	____	____	If so, when was it placed?_____
HIV positive	____	____	
Epilepsy or seizures	____	____	
Cold sores/Herpes	____	____	
Need premedication	____	____	

Have you ever had any other serious illness not listed above? If yes, explain:_____

Are you taking any medications, aspirin or drugs? If yes, list them

_____

_____

Women: Are you pregnant or is there a chance you could be pregnant?_____

Pharmacy Name & Phone Number:_____