

Boyle Heights Dental Care
2206 E. Cesar E. Chavez Ave
Los Angeles, CA 90033
323-265-3680

MEDICAL HEALTH HISTORY

Medical Conditions: (Please check any that apply)

- Cancer or tumor: _____
- Heart ailment or Chest Pain
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve: _____
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition _____
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding
- Hayfever or sinus trouble
- Allergies or hives
- Asthma
- Autoimmune condition: _____
- Hearing impaired

Do you smoke or use chewing tobacco? yes no

Do you drink alcohol? yes no

If yes, How many drinks per week? _____

Allergies/Adverse Reactions:

- Latex
- Penicillin/Amoxicillin/Augmentin
- Local anesthetics ("Novocain")
- Nitrous Oxide
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: _____

Current/Recent Medications:

- Aspirin
- Inhaler for Asthma (albuterol)
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Birth Control
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other: _____

Women Only:

Are you Pregnant? yes no

Expected delivery date: _____

Nursing? _____

Do you have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about: _____

Physician's Name: _____ Physician's Phone number: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Signature of Patient (or parent if minor) _____ Date _____

Dentist Signature: _____ Date: _____