Windsor Family Dentistry

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Medical History

To be completed every 2 years

Name: ____________________

Date: ____________________ BP: ____________________

Height: ____________________

Weight: ____________________

Do you have a Primary Physician? Yes / No	Physician's Name:	Physician's Phone:	Date of Last Visit:
Your current physical health is: ☐ Good ☐ Fair ☐ Poor		Do you use tobacco in any form? Yes / No (Circle which applies) Cigarettes or Smokeless	
Are you currently under a physician's care? Yes / No	Please Explain:		
Have you had any metal rods, pins or implants placed? Yes / No	Are you taking any medications? Yes / No	Please list each one:____________________	
Have you had any surgical	Please list each one:		

Conditions	Yes	No	Conditions	Yes	No	Conditions	Yes	No
Abnormal Bleeding			Glaucoma			Sinus Problems		
Alcohol Abuse			HIV + AIDS			Stroke		
Anemia			Heart Attack			Thyroid Problems		
Angina Pectoris			Heart Murmur			Tuberculosis		
Arthritis			Heart Surgery			Ulcers		
Artificial Heart Valve			Hemophilia			**Allergies**	**Yes**	**No**
Asthma			Hepatitis (circle) A / B / C			Asprin		
Blood Transfusion			High Blood Pressure			Codeine		
Cancer			Joint Replacement			Dental Anesthetics		
Chemotherapy			Kidney Problems			Erythromycin		
Claustrophobia			Liver Disease			Jewelry		
Colitis			Low Blood Pressure			Latex		
Congenital Heart Defect			Mitral Valve Prolapsed			Metals		
Diabetes			Osteoporosis			Penicillin		
Difficulty Breathing			Pace Maker			Sulfa		
Drug Abuse			Psychiatric Problems			Tetracycline		
Emphysema			Radiation Therapy			Other:		
Epilepsy			Rheumatic Fever					
Fainting Spells			Seizures			**If Female, Please Answer**	**Yes**	**No**
Fever Blisters			Sexually Transmitted Disease			Are you taking Birth Control Pills?		
Frequent Headaches			Shingles			Are you pregnant? # of wks_____		
Gag Reflex			Sickle Cell Disease			Are you nursing?		

Patient's/Guardian Signature: *Date:*