



# Medical History

HomeRun Dental  
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Patient \_\_\_\_\_

Physician \_\_\_\_\_ Date Of Last Visit \_\_\_\_\_

Please list all medications you are currently taking with dosage:

\_\_\_\_\_  
\_\_\_\_\_

List all allergies:

\_\_\_\_\_

Are you pregnant?  Yes  No    Nursing?  Yes  No    Taking birth control pills?  Yes  No

Indicate which of the following you have had, or have at present? (Check all that apply).

- AIDS
- Allergies or Hives
- Anemia
- Anxiety Problems
- Arthritis, Rheumatism
- Artificial Heart Valves
- Artificial Joints
- Asthma
- Back Problems
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Circulatory Problems
- Cold Sores
- Cortisone Treatments
- Cough, Persistent
- Cough up blood
- Diabetes
- Epilepsy
- Fainting
- Glaucoma
- Headaches
- Heart Murmur
- Heart problems
- Hemophilia
- Hepatitis
- High Blood Pressure
- HIV Positive
- Jaw Pain
- Kidney Trouble
- Latex Sensitivity
- Liver Disease
- Mitral Valve Prolapse
- Neurological Problems
- Pacemaker
- Psychiatric Care
- Radiation Treatment
- Rheumatic Fever
- Scarlet Fever
- Shortness of Breath
- Sinus Problems
- Skin Rash
- Stroke
- Swelling of Feet/Ankles
- Thyroid Problems
- Tobacco Habit
- Tonsillitis
- Tuberculosis
- Ulcers
- Venereal Disease

Other: \_\_\_\_\_  
\_\_\_\_\_

Please describe any positive responses from the list above:

\_\_\_\_\_  
\_\_\_\_\_

Do you smoke?  Yes  No Describe \_\_\_\_\_

Do you use alcohol?  Yes  No Describe \_\_\_\_\_

Do you use recreational drugs?  Yes  No Describe \_\_\_\_\_

Have you had surgery or been hospitalized in the last 5 years?  Yes  No Describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date: \_\_\_\_\_

History Review \_\_\_\_\_ History Review \_\_\_\_\_ History Review \_\_\_\_\_ History Review \_\_\_\_\_