Mark W. Schuyler, D.D.S

HEALTH HISTORY

Physician's Name: ______________________ Date of Last Visit: ____________

	Yes	No		Yes	No		Yes	No
AIDS / HIV	☐	☐	Fainting or Dizziness	☐	☐	Scarlet Fever	☐	☐
ANEMIA	☐	☐	Glaucoma	☐	☐	Shortness of Breath	☐	☐
Arthritis, Rheumatism	☐	☐	*Heart Murmur	☐	☐	Sinus Trouble	☐	☐
*Artificial Heart Valves	☐	☐	Heart Problems	☐	☐	Skin Rash	☐	☐
*Artificial Joints	☐	☐	Hepatitis Type ________	☐	☐	Special Diet	☐	☐
Asthma	☐	☐	Herpes	☐	☐	Stroke	☐	☐
Back Problems	☐	☐	High Blood Pressure	☐	☐	Swollen Feet or Ankles	☐	☐
Bleeding abnormally, with extractions or surgery	☐	☐	Jaundice	☐	☐	Swollen Neck Glands	☐	☐
			Jaw Pain	☐	☐	Thyroid Problems	☐	☐
Blood Disease	☐	☐	Joint Replacement	☐	☐	Tonsillitis	☐	☐
Cancer	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
Chemical Dependency	☐	☐	Liver Disease	☐	☐	Tumor or Growth on Head or Neck	☐	☐
Chemotherapy	☐	☐	Low Blood Pressure	☐	☐			
Circulatory Problems	☐	☐	*Mitral Valve Prolapse	☐	☐	Ulcer	☐	☐
Congenital Heart Lesions	☐	☐	Nervous Problems	☐	☐	Venereal Disease	☐	☐
Cortisone Treatments	☐	☐	*Pacemaker	☐	☐	Others	☐	☐
Cough, persistent or bloody	☐	☐	Psychiatric Care	☐	☐	Comments: ____________		
Diabetes	☐	☐	Radiation Treatment	☐	☐			
Emphysema	☐	☐	Respiratory Disease	☐	☐			
Epilepsy	☐	☐	*Rheumatic Fever	☐	☐			

If yes to any of the starred conditions, please call prior to your appointment . . . Premedication may be required.

	Yes	No
Do you use tobacco products?	☐	☐
If yes, what and how often? ____________		
Do you use antidepressants or sleeping pills?	☐	☐
If yes, list name(s) ____________		

Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years?
If yes, please explain ____________

	Yes	No
Are you on any blood thinners, including aspirin?	☐	☐

If yes, what? ____________

Women:

	Yes	No
Are you pregnant?	☐	☐
If yes, when is your due date? ____________		
Taking birth control pills?	☐	☐
Are you taking hormones?	☐	☐

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

____

Pharmacy Name: ____________

Phone: (_____) ____________

ALLERGIES

☐ No Allergies ☐ Local Anesthetic
☐ Aspirin ☐ Penicillin
☐ Barbiturates (sleeping pills) ☐ Sulfa
☐ Codeine ☐ Other ____________
☐ Iodine
☐ Latex

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and team at the next appointment without fail.

Patient (Responsible Party) Signature **X** ______________________ Date __________