Pewaukee Smiles
DENTISTRY

Health History

Welcome to our practice!

Last name: _____ First name: _____ DOB: _____

Medical conditions – check all that apply:

- ☐ Acid reflux (GERD)
- ☐ Addison's Disease
- ☐ ADHD
- ☐ Azheimer's disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial fibrillation (AFib)
- ☐ Autism Spectrum Disorder
- ☐ Autoimmune disease
- ☐ Bipolar disorder
- ☐ Blood disease
- ☐ Cancer
- ☐ Canker sores
- ☐ Celiac Disease
- ☐ Clotting disorder
- ☐ Cold sores
- ☐ Congenital heart defects
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Down Syndrome
- ☐ DVT
- ☐ Ehler's Danlos Syndrome
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Gout
- ☐ Hashimoto's Disease
- ☐ Head injury
- ☐ Hearing loss
- ☐ Heart arrythmia
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heart stent
- ☐ Heart valve replacement
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ HIV
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Lichen Planus
- ☐ Liver disease
- ☐ Lyme Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous system disorder
- ☐ Organ transplant
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ PCOS
- ☐ Polymyalgia Rheumatica
- ☐ Pregnant – Estimated Due Date _____
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Schizophrenia
- ☐ Seasonal allergies
- ☐ Seizures
- ☐ Sjogren's Disease
- ☐ Sleep apnea
- ☐ Stomach ulcers
- ☐ Stroke or TIA
- ☐ Tourette Syndrome
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Turner Syndrome
- ☐ Ulcerative Colitis
- ☐ Venereal Disease
- ☐ Vertigo
- ☐ Williams Syndrome

Medical conditions not listed above:

_____

Allergies – list below:

_____

_____

_____

Medications – list below or provide med list:

_____

_____

_____

Do you take antibiotic premedication prior to dental visits? ☐ YES ☐ NO

If yes, please explain: _____

Would you consider yourself to be in fairly good health? ☐ YES ☐ NO

Have you been hospitalized within the last 5 years due to surgery or illness? ☐ YES ☐ NO

If yes, please explain: _____

Approximate date of last medical exam: _____

Physician's name and phone number: _____

Preferred pharmacy: _____

Do you currently or have you ever used any of the following?

☐ Cigarettes ☐ Chewing tobacco ☐ Vape ☐ Marijuana ☐ None

If yes, is this past or current? ☐ CURRENT ☐ PAST – QUIT DATE _____

I understand that in order for Pewaukee Smiles Dentistry to provide me with the safest, most effective treatment, I must provide a complete and accurate health history. I certify that there are no medical conditions, allergies, or medications I have which have not been listed above.

If signing for someone else, please provide your name and relationship to the patient:

_____

Name (printed): _____

Signature: _____

Date: _____