gordon DENTISTRY

Name:

Patient Health History

We will review this information with you at each visit. Please include current & past conditions

- ☐ Aids/HIV
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Allergies
- ☐ Artificial Heart Valves
- ☐ Artificial Joints (knee/hip)
- ☐ Asthma
- ☐ Blood Disease/Abnormal Bleeding
- ☐ Cancer or Tumors
- ☐ Chemotherapy
- ☐ Cortisone Treatments
- ☐ Diabetes
  Last AIC ____
- ☐ Dizziness
- ☐ Endocarditis
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Conditions
  Diagnosis ____
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date ____
- ☐ Pulmonary
  DS Type ____
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other ____

Name of Primary Physician ____ Phone ____

Please list all medications and herbal supplements ____

Allergies ☐ Penicillin ☐ Latex ☐ Other ____

Signature of patient, parent or guardian ____ Date ____