**Essential Dental~256-20 Horace Harding Expressway~Little Neck, NY 11362**

**Medical Health History**

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First Name Last Name Name of Physician Office Phone #

Please answer Yes or No to the following questions:

Yes No Yes No Yes No

O O Heart Problems O O Sinus Problems O O Thyroid Problems

O O Chest Pain O O Asthma O O Cancer or Tumor

O O Shortness of Breath O O Intestinal Problems O O Tuberculosis/Respiratory Disease

O O Blood Pressure Problem O O Ulcers O O Do you drink alcohol?

O O Heart Murmur O O Weight Gain or Loss O O Do you smoke?

O O Heart Valve Problem O O Constipation/Diarrhea O O Use recreational drugs?

O O Taking heart medication O O Kidney or Bladder Problems O O History of alcohol or drug abuse

O O Rheumatic Fever O O Bone or Joint Problems O O Jaundice or liver trouble

O O Pacemaker O O Arthritis O O HIV + AIDS

O O Artificial Heart Valves O O Back or Neck Pain O O Glaucoma

O O Blood Problems O O Joint Replacement O O Do you wear contact lenses?

O O Frequent Nose Bleeds O O Diabetes O O Hemophilia

O O Abnormal Bleeding O O Dry Mouth or Constantly thirsty O O Hepatitis? Type\_\_\_\_\_\_\_

O O Blood Disease O O Family History of Diabetes O O Fainting Spells

O O Ever require a blood transfusion O O Fainting Spells, Seizures, Epilepsy O O Herpes or other STD\_\_\_\_\_\_\_

O O Allergy Problems O O Stroke(s) O O Emphysema

O O Hay Fever O O Frequent or Severe Headaches O O Lung disease or COPD

Have you ever been pre-medicated for any dental procedure?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any serious trouble associated with dental treatment? If so, explain:

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Have you ever had surgery? If yes, please list:

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List ALL medications you CURRENTLY take (OTC and Prescription) and dosages:

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List ALL allergies (Example: Aspirin, Antibiotics, Latex, Foods):

For Women:

O Birth Control or Hormones O Possibly Pregnant

O Pregnant – Delivery Date\_\_\_\_\_\_\_\_\_ O Nursing

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify Essential Dental of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements, I agree not to hold Essential Dental or its employees liable in the event of death or injury.

Patient or Guardian signature Print Name Date

Date Updates Doctor’s Signature

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