HOLLEY
DENTAL GROUP
FAMILY | COSMETIC | SEDATION | IMPLANT

Medical History

Patient Name: _____ **Date of Birth:** _____

Check (✔) which answer best applies to you:

Do you have good overall health? ☐Yes ☐No

Has there been a change in your health history within the last year? ☐Yes ☐No

Have you been hospitalized for a serious illness or surgery within the last three (3) years? ☐Yes ☐No
If Yes, why? _____

Are you currently under the care of a Physician? ☐Yes ☐No
Why? _____

Are you currently taking any medications? If Yes, please list: ☐Yes ☐No
Medication Condition Prescribing Physician
_____
_____
_____

Have you been told by a Physician to Pre-Medicate before dental treatment? ☐Yes ☐No

Have you had any adverse reactions to any medications or drugs? ☐Yes ☐No
If so, please list:_____

Are you currently using: Recreational Drugs? ☐Yes ☐No
Tobacco, in any form? ☐Yes ☐No
Alcohol? ☐Yes ☐No

Have you experienced complications with previous dental treatment? ☐Yes ☐No

Are you in pain now? ☐Yes ☐No

Women: Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking Contraceptives? ☐Yes ☐No

Check (✔) if you have or have had problems with any of the following:

Recent Fever	☐Yes ☐No	Tumors	☐Yes ☐No	Asthma	☐Yes ☐No
Sinus Problems	☐Yes ☐No	Radiation Treatment	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Dizziness	☐Yes ☐No	Chemotherapy	☐Yes ☐No	Persistent Cough	☐Yes ☐No
Ringing in Ears	☐Yes ☐No	Swollen Ankles	☐Yes ☐No	Coughing up Blood	☐Yes ☐No
Headaches	☐Yes ☐No	Recent Weight Loss/Gain	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Fainting Spell	☐Yes ☐No	Easy Bruising	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Blurred Vision	☐Yes ☐No	Frequent Vomiting/Nausea	☐Yes ☐No	Jaundice	☐Yes ☐No
Eye Disease	☐Yes ☐No	Diarrhea/Constipation/etc.	☐Yes ☐No	Chest Pain (Angina)	☐Yes ☐No
Contact Lenses	☐Yes ☐No	Difficulty/Frequent Urinating	☐Yes ☐No	Bleeding Problems	☐Yes ☐No
Seizures	☐Yes ☐No	Blood in Urine	☐Yes ☐No	High Blood Pressure	☐Yes ☐No
Stroke	☐Yes ☐No	Kidney/Bladder Disease	☐Yes ☐No	Prosthetic Heart Valve	☐Yes ☐No
Psychiatric Care	☐Yes ☐No	Stomach Problems/Ulcers	☐Yes ☐No	Blood Transfusion	☐Yes ☐No

Dry Mouth	☐Yes	☐No	Joint Pain/Stiffness	☐Yes	☐No	Pacemaker	☐Yes	☐No
Fever Blisters	☐Yes	☐No	Artificial Joints	☐Yes	☐No	Anemia	☐Yes	☐No
Difficulty Swallowing	☐Yes	☐No	Arthritis, Rheumatism	☐Yes	☐No	Cardiovascular Disease	☐Yes	☐No
Diabetes, Type____	☐Yes	☐No	AIDS/HIV Positive	☐Yes	☐No	Please Explain:		
Hepatitis, Type____	☐Yes	☐No	Thyroid, Adrenal Disease	☐Yes	☐No			

Do you have or have you had any other diseases or medical problems **NOT** listed above? ☐Yes ☐No

If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I understand it is my responsibility to inform my doctor of any change in my health and/or medications.

Patient's Signature: _____ **Date:** _____