Heim & Carroll DMD LLC
Medical History

Name: _____ Date of Birth: _____ Occupation: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Primary Care Provider: Name _____ Town _____

List all medications, Vitamins, Herbal Supplements, Over the counter medications:

_____

_____

_____

_____

_____

_____

_____

Allergies:_____NONE _____Latex _____Novocaine _____Penicillin _____Sulfa _____Metals or Jewelry

Other: _____

Have you ever had or do you have any of the following medical conditions:

Heart Problems	Y	N	Psychiatric Care	Y	N	Bleeding Problems	Y	N
Irregular Heartbeat	Y	N	Depression	Y	N	Sleep Apnea	Y	N
Artificial Heart Valve	Y	N	Anxiety	Y	N	Snoring	Y	N
Heart Surgery	Y	N	Drug Abuse	Y	N	Daytime Sleepiness	Y	N
Heart Attack	Y	N	Alcohol Abuse	Y	N	Osteoporosis	Y	N
High Blood Pressure	Y	N	Seizures	Y	N	Frequent Headaches	Y	N
Breathing Problems	Y	N	Artificial Joints	Y	N	Stroke/TIA	Y	N
Asthma	Y	N	Hepatitis	Y	N	High Blood Sugar	Y	N
Emphysema	Y	N	GERD/Acid Reflux	Y	N	Low Blood Sugar	Y	N
Tuberculosis	Y	N	Immune Deficiency	Y	N	Organ Transplant	Y	N
Tobacco Use	Y	N	HIV AIDS	Y	N	Cancer	Y	N
Kidney Problems	Y	N	Thyroid Problems	Y	N	Radiation Therapy	Y	N

Do you have any other medical condition not listed above? Y N If yes, please explain.

_____

_____

Women:

Are you pregnant Y N Breastfeeding Y N Taking birth control medication Y N

The above information is correct and complete to the best of my knowledge. I understand that I must inform the dentist of any non-prescription drugs and illicit drugs that I am using since they may interact with drugs given by the dentist and potentially cause health consequences which may be severe and cause permanent disability or death.

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