GREGG A. HELVEY, D.D.S., MAGD, LTD.
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THANK YOU VERY MUCH FOR PROVIDING THE FOLLOWING INFORMATION. YOUR HEALTH AND WELL-BEING ARE OF PRIMARY IMPORTANCE TO US.

MEDICAL HISTORY

NAME ____________________

PHYSICIAN'S NAME ____________________ CITY ____________________

CHECK IF YOU HAVE EVER HAD THE FOLLOWING:

- ☐ **HEART MURMUR**
- ☐ **RHEUMATIC FEVER**
- ☐ **CONGENITAL HEART PROBLEMS**
- ☐ **HEART DISEASE**
- ☐ **MITRAL VALVE PROLAPSE**
- ☐ **ARTIFICIAL HEART VALVES OR JOINTS**
- ☐ **ULCERS**
- ☐ **STROKE**
- ☐ **BLEEDING PROBLEMS**
- ☐ **ANEMIA**
- ☐ **INFECTIOUS DISEASES (CURRENTLY)**
- ☐ **TUBERCULOSIS OR LUNG DISEASE**
- ☐ **JAUNDICE**
- ☐ **EPILEPSY OR SEIZURES**
- ☐ **THYROID DISORDER**
- ☐ **ASTHMA OR HAYFEVER**
- ☐ **SINUS TROUBLE**
- ☐ **ARTHRITIS**
- ☐ **GLAUCOMA**
- ☐ **DIABETES**
- ☐ **HIV / AIDS**
- ☐ **CANCER**
- ☐ **RADIATION OR CHEMOTHERAPY**
- ☐ **HEPATITIS**
- ☐ **PREGNANT (CURRENTLY)**
- ☐ **ARE YOU TAKING BIRTH CONTROL**
  ☐ **YES** ☐ **NO**
- ☐ **ABNORMAL BLOOD PRESSURE**
  ☐ **HIGH** ☐ **LOW** ☐ **CONTROLLED**

ALLERGIES TO ANY OF THE FOLLOWING:

- ☐ **ASPIRIN**
- ☐ **PENICILLIN**
- ☐ **ERYTHROMYCIN**
- ☐ **LOCAL ANESTHETIC (NOVOCAIN)**

OTHER ANTIBIOTICS ____________________

OTHER MEDICATIONS ____________________

HOW LONG SINCE YOU HAVE SEEN A DENTIST? ____________________

ANY OTHER SIGNIFICANT HEALTH CONDITIONS OR MEDICAL CARE? ____________________

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PLEASE LIST ANY MEDICATIONS USED IN THE LAST THREE MONTHS. ____________________

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PLEASE ADVISE US OF ANY CHANGE IN YOUR MEDICAL HISTORY AT FUTURE APPOINTMENTS.

SIGNED ____________________ **DATE** ____________________

THANK YOU!