ARCH DENT
DENTAL CLINIC P.C.

Patient Medical History Checklist

Do you have any of the following:

High Blood Pressure	Yes	No	If yes, are you taking prescribed medication Yes No
Low Blood Pressure	Yes	No	
Chest Pain/Angina	Yes	No	
Heart Attack	Yes	No	If yes, date of Heart Attack_____
Irregular Heartbeat	Yes	No	
Cardiac Pacemaker	Yes	No	
Asthma	Yes	No	
Tuberculosis	Yes	No	
Do you smoke	Yes	No	
Blood Transfusion	Yes	No	
Bleeding tendency/abnormal bleeding	Yes	No	
Stroke	Yes	No	If yes, date of Stroke_____
Diabetes	Yes	No	If yes, are you taking prescribed medication Yes No
Are you blood thinners	Yes	No	If yes, Name of drug:_____
Do you have kidney problems	Yes	No	If yes, are you on dialysis Yes No
Are you allergic to penicillin	Yes	No	
Are you allergic to Codeine	Yes	No	
Do you have an autoimmune disease	Yes	No	
Have you had any surgeries within the past 2 years?		Yes	No
Did you take your prescribed medications today?	Yes	No	

If yes, list: _____

Patient's Signature:_____Date:_____

Reviewed By:_____Date:_____