NORTH APPLETON
DENTISTRY LLC
3521 Commerce Ct - Appleton, WI 54911

MEDICAL HEALTH HISTORY

Patient Name_____ **Date of Birth**___/_____/_____

Please circle the correct response:

Yes No Are you required to take a pre-med prior to dental appointments?

Yes No Do you take any blood thinners, including Aspirin?

Yes No Are being treated by a doctor for something other than routine care? Reason:
_____

Physician's Name: _____ Phone Number: _____

Yes No Have you had any surgeries? List: _____

Yes No Are you allergic or sensitive to any medications or substances? List: _____

Yes No Have you taken any bisphosphonates? (Fosamax, Boniva, Zometa, Aredia) For how long? _____

Yes No Do you have artificial joints or heart valves? Date placed & location in body: _____

Please list all prescription medications, supplements, or herbal medicaments you regularly take (or provide a copy of your complete medication / surgery list)**:**

_____

_____

Please check any illnesses, conditions, or diseases that you have had in the past or currently have:

☐	Acid Reflux	☐	Dizziness	☐	Kidney Disease	☐	Seizures
☐	Allergy / Hay Fever	☐	Epilepsy	☐	Low Blood Pressure	☐	Sinus Problems
☐	Alzheimer's	☐	Excessive Bleeding	☐	Malignant Hyperthermia	☐	Stomach Problems
☐	Anemia	☐	Fainting	☐	Mental Disorders	☐	Stroke
☐	Arthritis	☐	Glaucoma	☐	Nervous Disorders	☐	Thyroid Disease
☐	Aritficial Joints	☐	Head Injuries	☐	Osteoporosis	☐	Tuberculosis
☐	Artificial Valve	☐	Heart Disease	☐	Pacemaker	☐	Tumors
☐	Asthma	☐	Heart Murmur	☐	Psychiatric Treatment	☐	Tobacco Use
☐	Blood Disease	☐	Hepatitis	☐	Pregnancy	☐	Use of Other Substances
☐	Cancer	☐	High Blood Pressure	☐	Radiation / Chemotherapy	☐	Ulcers
☐	Cardiac Stents	☐	High Cholesterol	☐	Respriatory Problems	☐	
☐	Diabetes	☐	HIV / AIDS	☐	Rheumatic Fever	☐	

Any other health information not covered that you'd like to share: _____

Patient (or Guardian) Signature: _____ **Date:** _____