

# Woodruff Dental • Medical History

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ SS#/DL#: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact Information: \_\_\_\_\_

**If you have a new dental insurance, please have your card available and let us know.**

Please check yes or no, if you have, have ever, or have not had any of the following: *Do not leave anything blank.*

Anxiety / Nervous Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abnormal Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Endocarditis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type: _____			Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date: _____			Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back/Neck Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Thinners	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw Pain / T.M.J.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumor/Growth on Head/Neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mental Disorder(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcer(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough, Persistent or Bloody	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss, Unexplained	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**If you are female, please check if any the following currently apply (or you think they may apply) to you:**

Pregnancy     Yes     No      Nursing     Yes     No      Birth Control     Yes     No

**MEDICATIONS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES:**      Please Circle

Aspirin      Anesthetics

Barbiturates (Sleeping Pills)      Penicillin

Codeine      Sulfa

Iodine      Latex

Other \_\_\_\_\_

**Have you recently been hospitalized?** If yes, please explain: \_\_\_\_\_

**Please list any other medical concerns not listed on this form:** \_\_\_\_\_

\_\_\_\_\_ Please Initial that you have read and understand our cancellation and rescheduling policy:  
**Initial Here**

Hygiene appointments require 24 business hours notice to cancel or reschedule: **Penalty: \$45.00 Charge**

Doctor appointments require 48 business hours notice to cancel or reschedule: **Penalty: \$100.00 Charge**

To the best of my knowledge, the above information is complete and correct. I understands that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_