Medical History

The Tooth Company
424 E Lincoln Highway
New Lenox, IL 60451
p: (815) 717-8089
TheToothCompanyDental.com

Patient ______________________________

Physician ______________________________ Date Of Last Visit ______________

Please list all medications you are currently taking with dosage:

____

____

List all allergies:

____

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Indicate which of the following you have had, or have at present? (Check all that apply).

☐ AIDS	☐ Circulatory Problems	☐ Hepatitis	☐ Scarlet Fever
☐ Allergies or Hives	☐ Cold Sores	☐ High Blood Pressure	☐ Shortness of Breath
☐ Anemia	☐ Cortisone Treatments	☐ HIV Positive	☐ Sinus Problems
☐ Anxiety Problmes	☐ Cough, Persistent	☐ Jaw Pain	☐ Skin Rash
☐ Arthritis, Rheumatism	☐ Cough up blood	☐ Kidney Trouble	☐ Stroke
☐ Artificial Heart Valves	☐ Diabetes	☐ Latex Sensitivity	☐ Swelling of Feet/Ankles
☐ Artificial Joints	☐ Epilepsy	☐ Liver Disease	☐ Thyroid Problems
☐ Asthma	☐ Fainting	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Back Problems	☐ Glaucoma	☐ Neurological Problems	☐ Tonsillitis
☐ Blood Disease	☐ Headaches	☐ Pacemaker	☐ Tuberculosis
☐ Cancer	☐ Heart Murmur	☐ Psychiatric Care	☐ Ulcers
☐ Chemical Dependency	☐ Heart problems	☐ Radiation Treatment	☐ Venereal Disease
☐ Chemotherapy	☐ Hemophilia	☐ Rheumatic Fever	

☐ Other: ____

____

Please describe any positive responses from the list above:

____

____

Do you smoke? ☐ Yes ☐ No Describe ______________________________

Do you use alcohol? ☐ Yes ☐ No Describe ______________________________

Do you use recreational drugs? ☐ Yes ☐ No Describe ______________________________

Have you had surgery or been hospitalized in the last 5 years? ☐ Yes ☐ No Describe

____

____

Dentist's Signature ______________________________ Date: ______________

History Review ____________ History Review ____________ History Review ____________ History Review ____________