Olney Dental
Wellness
The Art & Science of Dentistry
Neal F. Hoyson, D.M.D.

Medical History

Date:_____/_____/_____

NAME (FIRST, MIDDLE, LAST)	AGE	DATE OF BIRTH
STREET ADDRESS		SEX ❑ MALE ❑ FEMALE
(CITY, STATE, & ZIP)		HOME PHONE
OCCUPATION		WORK PHONE
EMERGENCY CONTACT		EMERGENCY CONTACT PHONE
MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED		
CHILDERENS NAME (S) AND AGE (S)		

ALLERGIES TO MEDICATIONS?, ALLERGIC TO LATEX?, OR OTHER SUBTANCES? ❑ YES ❑ NO

(IF YES, PLEASE LIST THE NAME OF THE MEDICATION OR SUBSTANCE AND TYPE OF REACTION):

MEDICATIONS (PERSCRIPTION, OVER-THE-COUNTER, VITAMINS, HERBS, ETC.)

DRUG NAME	DOSE	DRUG NAME	DOSE

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Have you ever had or do you have at present? :

(*Please check each item that applies*)

❑ High or Low Blood pressure	❑ Blood Transfusion	❑ Sexually Transmitted Disease
❑ Heart disease or Heart Condition	❑ Sickle Cell Disease	❑ AIDS or AIDS Related Complex
❑ Congenital Heart Disease	❑ Other Blood Diseases	❑ HIV Positive
❑ Pacemaker	❑ Arthritis	❑ Herpes
❑ Angina Pectoris	❑ Asthma	❑ Thyroid Disease
❑ Frequent Chest Pain	❑ Sinus Trouble	❑ Epilepsy or Seizure Disorder
❑ Heart Attack	❑ Emphysema	❑ Fainting or Dizzy Spells
❑ Shortness of Breath	❑ Other Respiratory Disease	❑ Cold Sores
❑ Swollen Ankles	❑ Tuberculosis	❑ Jaundice
❑ Valve Disease	❑ Diabetes	❑ Hepatitis
❑ Heart Murmur	❑ Ulcers	❑ Liver Disease
❑ Rheumatic Fever	❑ Kidney Trouble	❑ Sleep Apnea
❑ Stroke	❑ Implant Prosthesis	❑ Drug / Alcohol Dependency
❑ Bleeding Disorder	❑ Frequent Headaches	❑ Depression
❑ Bruise Easily	❑ Joint Replacement	❑ Radiation Therapy
❑ Prolonged / Unusual Bleeding	❑ Cancer	❑ Chemotherapy
❑ Anemia	❑ G.I. Tract Problems	❑ Neurological Problems
❑ Premedication for Dental Treatment	❑ Psychiatric Treatment	❑ Thyroid Disease
❑ Post Nasal Drip	❑ Difficulty Swallowing	❑ Kidney Disease
❑ Nasal Discharge	❑ Soreness of Throat	❑ Other (Please Specify)

FAMILY HISTORY

Has any member of your family (including parents, Grandparents, and siblings) ever had the following?

Illness	Which Family Members?	Approx. Age When Diagnosed
Cancer (*Describe Type*)		
Hypertension (*High Blood Pressure*)		
Heart Disease		
Diabetes		
Strokes		
Mental Disease (*Anxiety Depression, Etc.*)		
Drug or Alcohol Addiction		
Glaucoma		
Bleeding Diseases		
Other		