# Butler Family Dentistry
# Medical History

Name:_____

Do you have, or have you had, any of the following:

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Angina | | | Convulsions | | | Fainting/Dizziness | | |
| Chest Pains | | | Alzheimers Disease | | | Hypertension | | |
| Heart Attack/Failure | | | Psychiatric Care | | | Hypotension | | |
| Heart Disease | | | Tuberculosis | | | Thyroid Disease | | |
| Heart Murmur | | | Asthma | | | Blood Transfusion | | |
| Heart Surgery | | | Breathing Problems | | | Sickle Cell Disease | | |
| Heart Valve Problem | | | Emphysema | | | Arthritis | | |
| Stroke | | | Lung Disease | | | Head Injury | | |
| Bleeding Problems | | | Swelling of Limbs | | | Hives/Rash | | |
| Excessive Bleeding | | | Kidney Disease | | | Cold Sores | | |
| Diabetes | | | Respiratory Disease | | | Tumors or Growths | | |
| Artificial Joint | | | Shortness of breath | | | Radiation Therapy | | |
| AIDS/HIV | | | Headaches | | | Chemotherapy | | |
| Hepatitis (Type____) | | | Liver Disease | | | Tobacco Use | | |
| Venereal Disease | | | Hearing Problems | | | COPD | | |
| Genital Herpes | | | Cancer (Type_____) | | | | | |
| Currently Pregnant | | | Stomach Disease | | | | | |
| History of Drug Abuse | | | Rhuematic Fever | | | | | |
| Cerebral Palsy | | | Anemia | | | | | |

Please list any allergies you may have:_____

Please list any medications you are taking:_____

_____

_____

Please list any surgeries you have had:_____

_____

_____ _____

Patient or Guardian Signature Date