CACHE VALLEY
WISDOM TEETH

Medical History Form

Patient Name: ______________________________________ Date of Birth: _____________________

1) Have you ever had any health problems with:

Heart_______________________________________ Diabetes_______________________________________

Lungs_______________________________________ Epilepsy____

Kidney______________________________________ High Blood Pressure _____________________________

Liver____ Low Blood Pressure______________________________

Asthma_____________________________________ Seizures____

Cancer______________________________________ Osteoporosis/Osteopenia _______________________

Depression/Anxiety/Mental Health____

Reaction to anesthetic________________________ Other Health Problems ___________________________
(General, Local, Sedation)

2) Allergies: ____
3) Medications routinely used at home____
____
4) Are you Pregnant? ______________ If yes, how far along? ______________ Nursing ______________
5) Past surgeries:

Dates Operation Type of Anesthesia (General, local, Sedation)

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6) Do you smoke?___________ Packs/day?________________ Number of years?____________________

7) Do you drink alcohol?___________ How often?____

8) Have you ever had any health problems we should know about? _________________________________

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____ _____________________________________
Patient's or Guardian's Signature Date

____ _____________________________________
Witness's Signature Date

____ _____________________________________
Doctor's Signature Date