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)

_____

_____

6) Do you vape or smoke?_____ Packs per day/frequency?_____
Number of years?_____

7) Do you drink alcohol?_____ How often?_____

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

_____

_____ _____
Patient's or Guardian's Signature Date

_____ _____
Witness's Signature Date

_____ _____
Doctor's Signature Date