Stummer Dental and Sleep Medicine Center

MEDICAL HISTORY
FOR
_____

Please indicate any condition below that you have or that you have had.

- ____ Acid Reflux
- ____ Positive for AIDS/HIV
- ____ Alzheimer's Disease
- ____ Anaphylaxis
- ____ Anemia
- ____ Angina
- ____ Arthritis/Gout
- ____ Artificial Heart Valve
- ____ Artificial Joint
- ____ Asthma
- ____ Blood Disease
- ____ Blood Transfusion
- ____ Breathing Problem
- ____ Cardiac Pacemaker
- ____ Cancer
- ____ Chemotherapy
- ____ Chest Pains
- ____ Cold Sores/Fever Blisters
- ____ Contagious diseases
- ____ Convulsions, Epilepsy, Seizures
- ____ Cortisone Medications
- ____ Diabetes
- ____ Easily Winded
- ____ Emphysema
- ____ Excessive Bleeding
- ____ Fainting Spells/Dizziness
- ____ Glaucoma
- ____ Hay Fever
- ____ Heart Attack/Failure
- ____ Heart Valve Damaged
- ____ Heart Trouble/Disease
- ____ Hemophilia
- ____ Hepatitis A,B or C
- ____ Herpes
- ____ High Blood Pressure
- ____ High Cholesterol
- ____ Hive/rashes
- ____ Hypoglycemia
- ____ Immunocompromised
- ____ Irregular Heartbeat
- ____ Jaw Joint pain
- ____ Joint replacement
- ____ Kidney disease/problems
- ____ Leukemia
- ____ Liver Disease
- ____ Low Blood Pressure
- ____ Lung Disease
- ____ Mitral Valve Prolapse
- ____ Osteoporosis
- ____ Psychiatric Care
- ____ Radiation Treatments
- ____ Recent Weight Loss
- ____ Renal Dialysis
- ____ Rheumatic Fever
- ____ Rheumatism
- ____ Shingles
- ____ Sickle Cell Disease
- ____ Sinus Trouble
- ____ Snoring/sleep apnea
- ____ Stomach/Intestinal Disease
- ____ Stroke
- ____ Thyroid Disease
- ____ Tuberculosis
- ____ Tumors or Growths
- ____ Ulcers
- ____ Venereal Disease

To the best of my knowledge, I have answered the questions on this history accurately
It is my responsibility to inform this office of any change to my medical/dental status.

Signature_____Date_____
patient, parent, guardian or custodian