KOHLMEIER DENTAL LLC

HEALTH HISTORY

Patient Name: _____

DOB: _____

Summary

Medical Conditions	
Allergies	

General Health Information

Are you currently under the care of a physician?	
Physician phone number:	
Date of last physical exam:	
Are you presently being treated for any injury or illness?	
Have you ever been hospitalized for an injury or illness?	
Are you pregnant or planning to become pregnant?	
Are you currently breastfeeding?	
Are you required to take antibiotics before dental treatment?	
Are you taking any blood thinners?	
Do you use or have you ever used tobacco?	
Have you ever had an allergic reaction?	

Medical Conditions

Please check all conditions that you have history of or are currently being treated for.	
Do you have a history or are currently being treated for any Digestive conditions?	
Do you have a history or are currently being treated for any Heart or Circulatory conditions?	
Do you have a history or are currently being treated for any Neurological conditions?	
Do you have a history or are currently being treated for any Lung or Breathing conditions?	
Do you have a history or are currently being treated for any Autoimmune conditions?	
Head or neck injuries?	
Artificial Joint?	

High Cholesterol?	
History of cancer?	
Chemotherapy?	
HIV / AIDS?	
Osteoporosis / Osteopenia?	
Type I or Type II Diabetes?	
Anemia?	
Kidney disease?	
Liver disease?	
Thyroid disease?	
Any other medical condition we should know of?	

Medications

Please check all medications you are currently taking.	
Are you taking any pain medications?	
Are you taking any Antidepressants or Anxiety medications?	
Are you taking any Diabetes, Cholesterol, or Blood Pressure Medications?	
Are you taking any Allergy or Asthma medications?	
Are you taking any Antibiotics?	
Are you currently taking any other medications or dietary supplements?	

Please list all medications, doses and reason:

_____

_____

Signature: _____ **Date:** _____