Dr. Azra Saleem, D.D.S.

MEDICAL HISTORY FORM

Patient Name:_____ **Date:**_____

ALL PATIENTS PLEASE COMPLETE FORM BELOW :

Any History of issues when given Dental Injections or Novocain? **Yes / No , If Yes**, Please Explain:_____

Allergies: **Yes / No , If yes**, please explain:_____

Are you pregnant? **Yes / No** : Are you on Contraceptives? **Yes / No**

Do you smoke? **Yes / No** How long?_____

Diabetes : **Yes / No**

Swollen Glands / Thyroid Issues: **Yes / No**

Sleep issues: **Yes / No**

Trouble Chewing, Biting, or Sores in mouth : **Yes / No**

Bulimia or Anorexia: **Yes / No**

AIDS or HIV: **Yes / No**

Tuberculosis: **Yes / No**

Seizures or Epilepsy: **Yes / No**

Hepatitis, Jaundice, or Liver Disease: **Yes / No**

Stomach Issues: **Yes/ No**

Asthma, Respiratory Issues, Cough, Bronchitis: **Yes / No**

Cancer: **Yes / No , If yes** please explain:_____

Anxiety, Fear, Mental Health Issues: **Yes / No**

Heart Disease: **Yes / No** High Blood Pressure: **Yes / No**

MEDICATIONS:_____