Gerald M. Winkler D.M.D., P.C.
Master Creator Of Healthy Smiles

4 Cabot Place, Suite 8
Stoughton, MA 02072
Phone: (781) 341-WINK (9465)
Fax: (781) 341-9234
contactus@drgeraldmwinkler.com
www.drgeraldmwinkler.com

# MEDICAL HEALTH HISTORY

**Patient Name** _____ Date of Birth_____

Primary Care Physician _____ Date of last physical_____

Physician Telephone (_____) _____-_____

Do you consider yourself to be in good health? _____yes _____no

If no, explain _____

Have you experienced any serious illnesses or operations? _____yes _____no

If yes, describe_____

**(WOMEN)** Are you pregnant _____ Nursing _____ Taking birth control pills _____

**Please list medications you are currently taking in space provided below. Or we can attach your list.**

**MEDICATIONS:**_____,_____,_____,_____

_____,_____,_____,_____

**ALLERGIES:** Aspirin □ Acrylics □ Codeine □ Other Narcotics □ _____

Latex Rubber □ Local Anesthetics □ Metals □ Penicillin □

OtherAntibiotics □_____Other Allergies □ _____

**Please circle if you have or have had any of the following:**

AIDS
Anemia
Arthritis, Rheumatism
Artificial Heart Valves
Artificial Joints
Asthma
Back Problems
Blood Disease
Cancer
Chemical Dependency
Chemotherapy
Chronic Fatigue
Circulatory Issues
Contact Lenses
Cough - Persistant
Coronary Stent
Diabetes
Epilepsy
Fainting
Headaches
Heart Murmur
Heart Problems
Describe:
_____
Hemophilia
Hepatitis **A B** or **C**
High Blood Pressure
HIV Positive
Insomnia
Kidney Disease
Liver Disease
Mitral Valve Prolapse
Pacemaker
Psychiatric Care
Pulmonary Shunt
Radiation Treatment
Respiratory Disease
Rheumatic Fever
Shortness of Breath
Skin Rash
Sleep Apnea
Stroke
Swelling of Feet/Ankles
Thyroid Problems
Tobacco Habit- Smoke/Chew
Tonsilitis
Tuberculosis
Ulcer
Venereal Desease
Other STD's
_____

History of/or presently taking Bisphosphonates for Osteoporosis ( Boniva □ Fosamax □ Actonel □ )

Do you have any illness or medical condition not listed above that you think I should be aware of?

Please explain_____

My **signature** acknowledges this information to be an accurate account of my health history. I understand providing correct information is vital to my comprehensive dental care.

Patient/Parent if minor/Guardian_____Date_____

**Medical Health History reviewed by Dr. Winkler_____Date_____**