MEDICAL HISTORY

NAME ____ _____ BIRTHDATE _____
Physician's Name _____ Phone _____
Address _____
Are you currently under the care of a physician? ☐ Yes ☐ No
If Yes, for what reason? _____
Please list all of the medications that you are taking in the box to the right →→→→→→
Have you ever taken prescription drugs for weight loss (i.e. PhenFen or Redux)? ☐ Yes ☐ No
Have you ever taken medications for Osteoporosis (i.e. Fosomax, Aredia, Boniva? ☐ Yes ☐ No
Are you, or have you ever taken any "Blood Thinners" (i.e. Coumadin, Plavix) ☐ Yes ☐ No
Do you currently, or have you had to, take antibiotics before dental treatment? ☐ Yes ☐ No

List **ALL** medications including prescription, over-the-counter, vitamins and supplements:

ALLERGIES

Are you allergic (or have an adverse reaction) to: *Check all that apply or check none*

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ None
☐ Aspirin ☐ Other Antibiotics ☐ Other Medications or Substances

Are you sensitive or allergic to latex? (Have you experienced itching, rash or wheezing after using latex gloves or handling a balloon) ☐ Yes ☐ No
Have you had any unusual or unexplained reactions during a surgical procedure? ☐ Yes ☐ No Explain: _____
Hearing impaired? ☐ Yes ☐ No

Do you have, or have you ever had any of the following. (Yes or No)

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery	☐	☐	Asthma	☐	☐	Artificial Joint	☐	☐	Hepatitis (check one)	☐	☐
Heart Murmur	☐	☐	Shortness of Breath	☐	☐	Prosthetic Implants	☐	☐	Type: ☐ A ☐ B ☐ C		
Heart pacemaker	☐	☐	Respiratory Ailments	☐	☐	Cancer	☐	☐	Ulcers	☐	☐
Rheumatic fever	☐	☐	Tuberculosis	☐	☐	Radiation Therapy	☐	☐	Stomach Disorders	☐	☐
Rheumatic heart disease	☐	☐	Sinus Trouble	☐	☐	Chemotherapy	☐	☐	Organ Transplant	☐	☐
Congenital heart disease	☐	☐	Chronic Cough	☐	☐	Prolonged Bleeding	☐	☐	Glaucoma	☐	☐
Artificial heart valve	☐	☐	Thyroid Problems	☐	☐	Leukemia	☐	☐	Cortisone medicine	☐	☐
Mitral valve prolapse	☐	☐	Kidney Problems	☐	☐	Blood Disorders	☐	☐	Arthritis/Rheumatism	☐	☐
High Blood Pressure	☐	☐	Sexually Transmitted Disease	☐	☐	Hemophilia	☐	☐	Neurological disorders	☐	☐
Low Blood Pressure	☐	☐	HIV positive/AIDS/ARC	☐	☐	Anemia	☐	☐	Epilepsy	☐	☐
Sleep disorders	☐	☐	Stroke	☐	☐	GERD (gastric reflux)	☐	☐	Osteoporosis	☐	☐
Sleep Apnea	☐	☐	Fainting Spells	☐	☐	Removal of spleen	☐	☐	Blood Transfusion	☐	☐
Diabetes	☐	☐	Anorexia/Bulimia	☐	☐	Liver disease	☐	☐			

DR COMMENTS:

☐ **Premedication Required** _____

Do you currently smoke or use the following tobacco products?
☐ Cigarette Packs/Day? ____ ☐ Cigars ☐ Pipe ☐ Chew ☐ None

Have you used tobacco products in the past? ☐ Yes ☐ No How long ago? _____

WOMEN: Are you pregnant? ☐ Yes ☐ No
Do you take any birth control medications? ☐ Yes ☐ No
If yes, please note: _____

Have you had any other serious illness, hospitalization or accident?
If yes, please explain _____

Would you like to speak to the doctor privately about any problem? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify this doctor of my changes in my health or medication.

Patient's Signature _____ Date _____
(PARENT/GUARDIAN OF A MINOR)