

# 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

## 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

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (check one)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Implants	<input type="checkbox"/>	<input type="checkbox"/>	Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/>	<input type="checkbox"/>
Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Ailments	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone medicine	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive/AIDS/ARC	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disorders	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	GERD (gastric reflux)	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Removal of spleen	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia/Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>			

DR COMMENTS:

**Premedication Required** \_\_\_\_\_

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

**WOMEN:** Are you pregnant?  Yes  No  
 Do you take any birth control medications?  Yes  No  
 If yes, please note: \_\_\_\_\_

Have you used tobacco products in the past?  Yes  No How long ago? \_\_\_\_\_

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)