

Patient Name:	Home phone:	Cell phone:
Patient Address:	Email Address:	
	Emergency Contact Name and phone number:	

MEDICAL HISTORY

Family Physician's Name: _____ **Phone Number:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____

- 1.) Have you been under the care of a medical doctor during the past two years? Yes No
If yes, for what? - _____
- 2.) **Do you need to Premedicate before Dental visits?** Yes No **Or have you had an artificial joint replacement?**
- 3.) Are you **currently** taking any medications, over-the-counter medications, herbs or vitamins? Yes No
If yes, please list name and dosage: _____

- 4.) Are you aware of having an **ALLERGIC** (or Adverse Reaction) to any **Medication/Drug, Substance** or **Food**? Yes No
If yes, please list: - _____
- 5.) Have you been hospitalized during the past five years? _____ Yes No
- 6.) Indicate which of the following you have had or have at present. **Please check "Yes" or "No" to each item.**

- | | | |
|--|---|---|
| Heart (surgery, disease, attack) <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A, B, or C <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | A.I.D.S. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No | H.I.V. Positive <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Cough <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies or Hives <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No | LATEX Sensitivity <input type="checkbox"/> Yes <input type="checkbox"/> No | TMJ surgery/issues <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches/Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulation Problems /Blood Clots <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diet (special/restricted) <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizzy Spells <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints (hip, knee, etc) <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous/Anxious <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No | | Psychiatric/Psychological <input type="checkbox"/> Yes <input type="checkbox"/> No |

Ulcers Yes No

- 7.) **Do you take any Blood thinners, Aspirin, Fish Oil or Vitamin-E?** _____ Yes No

- 8.) Do you have or have you had any **Disease, Condition, or Problem** not listed? Yes No

If yes, please list: _____

9.) **Women:**

Are you: **Pregnant?** Yes ___ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

- 10.) **Have you ever taken or are you currently taking any medication for Osteopenia/Osteoporosis?** Yes No

If yes, please list (such as, Fosamax, Boniva, Actonel, Prolia, etc.) _____ **IV or Oral**

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 the doctor of any changes in my health or medication.

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____