MEDICAL HISTORY

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Are you now under the care of a physician? Yes ☐ No ☐
If yes, for what reason? _____
Physician's Name: _____
Are you allergic to any medication or substances? Yes ☐ No ☐
☐ Penicillin ☐ Latex ☐ Metals ☐ Other _____
Have you ever had a serious accident, hospitalization, or major operation? Yes ☐ No ☐
If yes, please explain: _____
Have you ever taken Fosamax, Boniva, or any other bisphosphonate drug? Yes ☐ No ☐
Do you currently smoke or use the following tobacco products?
☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew ☐ None
If so, how much? _____
Are you interested in quitting at this time? Yes ☐ No ☐
Have you ever been told that you need antibiotics before dental treatment? Yes ☐ No ☐
Would you like to speak to the Doctor privately about any problem? Yes ☐ No ☐

WOMEN: Are you pregnant or trying to get pregnant? Yes ☐ No ☐
Are you nursing? Yes ☐ No ☐
Do you take any birth control medications? Yes ☐ No ☐

Do you have, or have you had any of the following: **(check *yes* or *no*)**

	Yes	No		Yes	No		Yes	No
Heart Disease/Surgery	☐	☐	Osteoporosis	☐	☐	Dementia	☐	☐
Rheumatic fever	☐	☐	Kidney Problems	☐	☐	Epilepsy	☐	☐
Artificial heart valve	☐	☐	High/Low Blood Pressure	☐	☐	Stroke	☐	☐
Learning disability	☐	☐	Sexually Transmitted Infection	☐	☐	Arthritis/Rheumatism	☐	☐
Psychiatric care	☐	☐	HIV positive/AIDS	☐	☐	Prosthetic Implants	☐	☐
Anorexia	☐	☐	Alcohol addiction	☐	☐	Artificial Joint	☐	☐
Bulimia	☐	☐	Drug dependency	☐	☐	Liver disease	☐	☐
Lung disease	☐	☐	Chemical dependency	☐	☐	Hepatitis (circle one)	☐	☐
Tuberculosis	☐	☐	Blood Disorders	☐	☐	Type A B C		
Asthma	☐	☐	Anemia	☐	☐	Ulcers	☐	☐
Shortness of Breath	☐	☐	Leukemia	☐	☐	Stomach disorder	☐	☐
Respiratory Ailments	☐	☐	Prolonged Bleeding	☐	☐	GERD (gastric reflux)	☐	☐
Emphysema	☐	☐	Hemophilia	☐	☐	Hearing Impaired	☐	☐
Heart pacemaker	☐	☐	Sickle Cell disease	☐	☐	Glaucoma	☐	☐
Sinus Trouble	☐	☐	Cancer	☐	☐	Cortisone Medicine	☐	☐
Diabetes	☐	☐	Chemotherapy	☐	☐	Fainting spells	☐	☐
Thyroid Problems	☐	☐	Radiation Therapy	☐	☐	Organ Transplant	☐	☐
			Neurological disorder (ex. Fibromyalgia, Lupus)	☐	☐	Alzheimer's	☐	☐

Have you had any other illness/condition not checked above? Yes ☐ No ☐
If yes, please describe _____

PLEASE CONTINUE ON BACK ➡

Please list any medications including vitamins, herbal supplements, or over-the-counter drugs taken:

MEDICATION NAME	**USE**

DOCTOR COMMENTS:

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 if 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 Signature: _____ Date: _____

(PARENT / GUARDIAN OF A MINOR)

Doctor Signature: _____ Date: _____