

Medical History

Patient Name _____ Birthdate: _____

WELCOME, Please take the time to complete this form with your current medical information. You, and your families medical history will influence your susceptibility to certain dental conditions. The following information should be as complete and accurate as possible as we use it to select the most appropriate dental care for you. Please inform us of any changes to your medical history in the future.

Physician's Name _____ Physician's Address _____

Date of your last medical physical: _____ Are you currently under the care of a physician? Y / N
Why? _____

Please check and/or circle any of the following conditions that you have or have had in the past:

- | | | | | |
|---|--|---|---|--------------------------------------|
| <input type="checkbox"/> Prosthetic Joint Replacement Date: _____ | <input type="checkbox"/> Tuberculosis | | | |
| <input type="checkbox"/> Artificial Heart Valve Implant | <input type="checkbox"/> Breathing problems: Asthma, COPD, Emphysema | | | |
| <input type="checkbox"/> Heart Disease or Heart Problems | <input type="checkbox"/> Cancer, Type: _____ | | | |
| <input type="checkbox"/> Heart Attack or Chest Pains | <input type="checkbox"/> Epilepsy or Seizures | | | |
| <input type="checkbox"/> Pacemaker or Defibrillator | <input type="checkbox"/> Fainting or Dizzy Spells | | | |
| <input type="checkbox"/> Blood Pressure Problems: High / Low | <input type="checkbox"/> Nervous Problems | | | |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Psychiatric or Emotional Treatment | | | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Frequent Headaches, Shoulder or Neck Aches | | | |
| <input type="checkbox"/> Aspirin or Anticoagulant Use | <input type="checkbox"/> Sinus Problems | | | |
| <input type="checkbox"/> Anemia/Blood Disorders | <input type="checkbox"/> Sight or Senses Impairment | | | |
| <input type="checkbox"/> Kidney/Liver Disease or Problems | <input type="checkbox"/> Osteopenia or Osteoporosis | | | |
| <input type="checkbox"/> Diabetes: Type 1 or Type 2 | <input type="checkbox"/> Stomach Problems or Ulcers | | | |
| <input type="checkbox"/> Hepatitis, Type: _____ | <input type="checkbox"/> Thyroid: Hypothyroid/Hyperthyroid | | | |
| <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Herpes/Cold Sores/Shingles | | | |
| <input type="checkbox"/> Immunosuppressive Condition (<i>Circle all that apply</i>) | | | | |
| <input type="checkbox"/> Steroid Therapy (e.g. prednisone) | <input type="checkbox"/> Radiation or Cancer Therapy | <input type="checkbox"/> Organ Transplant, Type _____ | | |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> HIV | <input type="checkbox"/> SLE (Lupus) | <input type="checkbox"/> Spleen Removed | <input type="checkbox"/> Other _____ |

Have you ever had a disease condition, serious illness or major surgery not listed above? Y / N *If yes, please explain:* _____

Have you taken the prescription drugs Fen-phen or Redux? Y / N *If yes, what:* _____

Have you ever taken Fosamax, Boniva, Actonel or other Oral or IV bisphosphonates? Y / N *If yes, what:* _____

Is there a family history of Diabetes, Heart Disease, Oral Cancer, or Periodontal Disease? Y / N *Circle those that apply.*

Would you describe your stress level as high, average, or low? *Circle one.*

Do you smoke, chew, use snuff, or any other forms of tobacco? Y / N *Circle those that apply.*

How long? _____ *How much?* _____ *Are you interested in quitting?* _____

Do you consume alcoholic beverages or use recreational drugs? Y / N *Circle those that apply.*

Please list any medications you are currently taking,

Include prescription and non-prescription:

List any health related substances you take routinely.

Include any vitamins, supplements, or natural products.

If female, please answer the following:

Do you use Birth Control medications Y / N

Are you pregnant? Y / N *If Yes, # of weeks* _____

Are you nursing? Y / N

Yes / No List All Allergies

- | | | |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | Sulfa |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Jewelry or Metals |

Other: _____

I certify that the above information is complete and accurate.

Patient/Guardian Signature _____ Date: _____

Dentist's Signature _____ Date: _____