MEDICAL HISTORY

Name (above) Last First Initial Today's Date

Address City State Zip Code

Home Phone Cellular Business Email Address

Birth Date M/F Employer/Occupation Social Security #

Marital Status Spouse's Name Family/Referring Dentist

Person to Notify in Case of Emergency Phone Number

Dental Insurance (Circle) No Yes (If yes, please fill out Dental Insurance Form)

YOUR ANSWERS ARE FOR YOUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL

Any health changes in the last year? _____Please Explain _____

Serious illness or hospitalized within the past five years? _____

PLEASE CHECK ANY/ALL CONDITIONS THAT APPLY

Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Instructed to take a pre-medication prior to dental appointments?
☐	☐	Heart Attack/Stroke_____			☐ Valvular Heart Disease/Heart
☐	☐	Pacemaker			☐ Murmur/Mitral Valve Prolapse
☐	☐	Other Heart_____			☐ Bacterial Endocarditis
☐	☐	Hepatitis A,B,C			☐ Artificial Joint
☐	☐	AIDS/HIV-positive			☐ Shunts/Pulmonary, Renal, AV
☐	☐	Diabetes-			
		Insulin or Diet/Med. Controlled (Circle One)	☐	☐	Cancer (Type) _____
☐	☐	Hemophilia/Abnormal Bleeding	☐	☐	Treatment Phase_____
☐	☐	Anemia	☐	☐	Transplants / Kidney, Heart, Etc…
☐	☐	Are you on a Blood Thinner?	☐	☐	Stomach Ulcers
☐	☐	Are you on Warfarin or Coumadin?	☐	☐	Women – Pregnant/Breastfeeding
☐	☐	Epilepsy/Seizures	☐	☐	Inflammatory Rheumatism/arthritis
☐	☐	Asthma	☐	☐	Osteoporosis_____
☐	☐	Tuberculosis	☐	☐	Have you taken Bisphosphonate in the past or currently?

Are you allergic or have you reacted adversely to:

Yes	No	
☐	☐	Latex
☐	☐	Local anesthetics
☐	☐	Penicillin/Amoxicillin
☐	☐	Clindamycin
☐	☐	Other Antibiotics (Name) _____
☐	☐	Sedatives or sleeping pills
☐	☐	Motrin/Advil
☐	☐	Codeine or other narcotics
☐	☐	Any other allergies to medications not listed_____

Please list <u>all</u> medications you are currently taking / and what the medication is for
(Prescription and Over the counter)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you had any serious trouble associated with previous dental treatment? _____

Chief Dental Complaint: _____

Patient Signature

_____

Updates:

Date	Changes	Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____