

Medical History

Patient Name _____

Parent/Guardian Name, if minor: _____

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 any of the following conditions that you have or have had in the past:

- | | |
|---|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Hepatitis, Type: |
| <input type="checkbox"/> Anemia/Blood disorders | <input type="checkbox"/> Herpes/Cold Sores/Shingles |
| <input type="checkbox"/> Any heart problems | <input type="checkbox"/> Kidney/Liver Problems |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Mental/Emotional Disorders |
| <input type="checkbox"/> Artificial Heart Valve Implant | <input type="checkbox"/> Nervous Problems |
| <input type="checkbox"/> Asthma/Hay fever | <input type="checkbox"/> Organ Transplant, Type: |
| <input type="checkbox"/> Blood Pressure Problems: High / Low | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer, Type: | <input type="checkbox"/> Prosthetic Joint Replacement Date: |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Radiation or Chemotherapy Why: |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Frequent Headaches, shoulder or neck aches | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Glaucoma or light sensitivity | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Tested Positive for HIV |
| <input type="checkbox"/> Diabetes: Type 1 or Type 2 | <input type="checkbox"/> Thyroid: Hypothyroid/Hyperthyroid |
| <input type="checkbox"/> Date Diagnosed _____ | <input type="checkbox"/> Controlled or Uncontrolled? By Medication or Diet? |

Have you ever taken Bisphosphonates such as Actonel, Boniva, Didronel, or Fosamax? Y / N If yes, what: _____

Have you ever taken any prescription weight loss products? Y / N If yes, what: _____

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

Is there a family history of Diabetes, Heart Disease, Oral Cancer, or Periodontal Disease? Y / N If yes, explain: _____

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 have you used tobacco? _____ How much do you use? _____

Have you ever quit or thought about quitting? _____ Are you interested in quitting? _____

Please list any medications you are currently taking,
Include prescription and non-prescription:

List any health related substances you take routinely.
Include vitamins, supplements, or natural products.

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"/> | Codiene |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Jewelry or metals |

Other: _____

If female, please answer the following:

Are you taking Birth Control Pills? Y / N

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

Are you nursing? Y / N

I certify that the above information is complete and accurate.

Patient/Guardian Signature _____ Date: _____

Dentist's Initials _____ Date: _____