Medical History

Patient Name ______________________________
Date of Birth ______________________________

WELCOME! *Please 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*

Physician's Name ______________________________ Clinic Name, Location ____________________
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:

❑Yes ❑No Acid Reflux, or GERD
❑Yes ❑No Alzheimer's or Dementia
❑Yes ❑No Anemia, Blood Disorders, Abnormal Bleeding
❑Yes ❑No Arthritis, Rheumatism, or Gout
❑Yes ❑No Artificial Heart Valve, Implant, or Pacemaker
❑Yes ❑No Asthma
❑Yes ❑No Autoimmune Disease, Type:
❑Yes ❑No Blood Pressure Problems: High / Low
❑Yes ❑No Cancer, Type:
❑Yes ❑No Cold Sores or Canker Sores
❑Yes ❑No COPD, Emphysema, or Difficulty Breathing
❑Yes ❑No Cystic Fibrosis
❑Yes ❑No Diabetes: Type 1 or Type 2
❑Yes ❑No Epilepsy or Seizures
❑Yes ❑No Fainting or Dizzy Spells
❑Yes ❑No Fibromyalgia
❑Yes ❑No Frequent Headaches, Shoulder or Neck Aches
❑Yes ❑No Glaucoma or Light Sensitivity
❑Yes ❑No Hay Fever or Sinus Problems
❑Yes ❑No Heart Attack or Heart Problems
❑Yes ❑No Heart Murmur
❑Yes ❑No Hepatitis, Type:
❑Yes ❑No Kidney/Liver Disease or Problems
❑Yes ❑No Mental/Emotional Disorders
❑Yes ❑No Mitral Valve Prolapse
❑Yes ❑No Nervous System Disease/Problems
❑Yes ❑No Organ Transplant, Type:
❑Yes ❑No Osteoporosis or Osteopenia
❑Yes ❑No Prosthetic Joint Replacement Date:
❑Yes ❑No Radiation or Chemotherapy Why:
❑Yes ❑No Sleep Apnea
❑Yes ❑No STD's: HPV, Venereal Disease, Other
❑Yes ❑No Stroke
❑Yes ❑No Tested Positive for HIV
❑Yes ❑No Thyroid: Hypothyroid/Hyperthyroid
❑Yes ❑No Tuberculosis

Do you have other health conditions or had major surgery not listed above? Y / N *If yes, explain:* __________
____
Have you ever been told to take antibiotics prior to your dental appointment? Yes/No ________________
Have you ever taken Bisphosphonates such as Actonel, Boniva, Didronel, or Fosamax? Y / N If yes, what:______
Is there a family history of Diabetes, Heart Disease, Oral Cancer, or Periodontal Disease? *Circle those that apply*
Would you describe your stress level as high, average, or low? *Circle one.*
Do you smoke, vape, 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? Y / N Do you use recreational drugs? Y / N

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
☐	☐	Latex
☐	☐	Penicillin
☐	☐	Sulfa
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics

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 Signature____ Date:______________

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