Medical History

Patient Name: ______________________________ **Birth Date:** _____________

Your overall health has an impact on your oral health. Medical problems or medications may have an effect on dental treatment you will receive. Thank you for carefully answering the following questions.

Name of Previous Dentist: ______________________________

Name of Primary Physician: ______________________________ Phone #____________________

Name of Preferred Pharmacy: ______________________________ Phone#____________________

Are you under a physician's care now? □ Yes □ No Reason:________________________________

Have you ever been hospitalized or had a major operation? □ Yes □ No
If yes: ____

Have you ever had a serious head or neck injury? □ Yes □ No If yes:____________________________

Are you on a specialized diet? □ Yes □ No Explain: ____________________________

Do you smoke, vape, or chew tobacco? □ Yes □ No How much? ______________________

Have you ever taken a medication for osteoporosis? □ Yes □ No Which? ____________________________

Are you currently on any blood thinners like Coumadin, Plavix, Eliquis, Xarelto, Aspirin, etc.? □ Yes □ No

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Sulfa Drugs □Other:____________________

□ Acrylic □ Metal □ Latex □ Local Anesthetics

Women: Are you...

□ Pregnant/Trying to get pregnant □ Nursing

□ Taking Oral Contraceptives/Birth Control □ Not applicable

Have you ever had complications following dental treatment? □ Yes □ No

If yes: ____

Do you have any dental problems that you are aware of? □ Yes □ No

If yes ____

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Current or past medical conditions. Please check yes or no:

AIDS/HIV □ Yes □ No
Anemia □ Yes □ No
Arthritis/Gout □ Yes □ No
Artificial Heart Valve □ Yes □ No
Artificial Joint □ Yes □ No
Asthma □ Yes □ No
Blood Disease □ Yes □ No
Blood Transfusion □ Yes □ No
Breathing Problems □ Yes □ No
Bruise Easily □ Yes □ No
Cancer □ Yes □ No
Celiac Disease □ Yes □ No
Chemotherapy/ Radiation □ Yes □ No
Chest Pains □ Yes □ No
Cold sores □ Yes □ No
COPD □ Yes □ No
Diabetes □ Yes □ No
Drug Addiction □ Yes □ No

Epilepsy/ Seizures □ Yes □ No
Excessive Bleeding □ Yes □ No
Fainting/ Dizziness □ Yes □ No
Glaucoma □ Yes □ No
Heart Attack □ Yes □ No
Heart Disease □ Yes □ No
Heart Murmur □ Yes □ No
Hemophilia □ Yes □ No
Hepatitis A, B, C □ Yes □ No
High or Low Blood Pressure □ Yes □ No
Hives/Rash □ Yes □ No
Irregular Heartbeat □ Yes □ No
Jaundice □ Yes □ No
Kidney Disease □ Yes □ No
Leukemia □ Yes □ No
Liver Disease □ Yes □ No
Mental Disease □ Yes □ No

Nervous Disorder □ Yes □ No
Osteoporosis □ Yes □ No
Pain in Jaw Joints □ Yes □ No
Pacemaker/ Defibrillator □ Yes □ No
Parathyroid Disease □ Yes □ No
Renal Dialysis □ Yes □ No
Shingles □ Yes □ No
Sickle Cell Disease □ Yes □ No
Sinus Trouble □ Yes □ No
Stomach Problems □ Yes □ No
Stomach Ulcers □ Yes □ No
Stroke □ Yes □ No
Thyroid Problems □ Yes □ No
Tonsillitis □ Yes □ No

Have you ever had any serious illness not listed above? □ Yes □ No
If yes: ____

Please list all medication you are taking. Include prescriptions, over the counter, vitamins/supplements.

Medication	**Reason for Medication**	**Dosage & Frequency**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature:____ **Date:**__________________

Yearly Update
Reviewed with patient on :_____________ □ No changes □ Updates ________________________ Pt. Initials:____
Reviewed with patient on :_____________ □ No changes □ Updates ________________________ Pt. Initials:____
Reviewed with patient on :_____________ □ No changes □ Updates ________________________ Pt. Initials:____