Patient Name: _____ Birth Date: _____

Although dental professionals primarily treat the area in and around your mouth, your mouth is important to the overall health of your body. Health problems that you may have or medications that you are taking could have an important interrelationship with the dentistry you will receive. Thank you for carefully answering the following questions.

Name of Primary Physician: _____ Phone #_____

Are you under a physician's care now? ☐ Yes ☐ No If yes_____

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
Do you smoke, use tobacco, or Vape? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No
Are you currently on any blood thinners such as Coumadin, Plavix, Xarelto, ect.? ☐ Yes ☐ No

Women: Are you...

P

Are you allergic to any of the following?

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 _____

How would you rate your smile?

Not Happy 1 2 3 4 5 6 7 8 9 10 Great

Patient Name: _____ Birth Date: _____

Please check yes or no for each listed item:

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
Chemotherapy ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No
Cold sores/ Fever blisters ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Defibrillator ☐ Yes ☐ No
Drug Addiction ☐ Yes ☐ No
Emphysema ☐ 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 ☐ Yes ☐ No
Hepatitis B or C ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
Hives/Rash ☐ Yes ☐ No
Irregular Heartbeat ☐ Yes ☐ No
Kidney Problems ☐ Yes ☐ No
Leukemia ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Low Blood Pressure ☐ Yes ☐ No
Mental Disease ☐ Yes ☐ No
Nervous Disorder ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No
Pain in Jaw Joints ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Parathyroid Disease ☐ Yes ☐ No
Radiation Treatment ☐ Yes ☐ No
Renal Dialysis ☐ Yes ☐ No
Shingles ☐ Yes ☐ No
Sickle Cell Disease ☐ Yes ☐ No
Sinus Trouble ☐ Yes ☐ No
Stomach Problems ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Thyroid Disease ☐ Yes ☐ No
Tonsillitis ☐ Yes ☐ No
Tumors or Growths ☐ Yes ☐ No
Ulcers ☐ Yes ☐ No
Venereal Disease ☐ Yes ☐ No
Yellow Jaundice ☐ Yes ☐ No

Have you ever had any serious Illness not listed above? ☐ Yes ☐ No If Yes, _____
_____

Please list all medication you are taking now. Include prescriptions, over the counter, vitamins, and 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.

X_____ Date:_____

Medical History Updated:

Date Patient Initials Staff Initials Updates

Patient Name: _____ Birth Date: _____

_____|_____|_____| _____
_____|_____|_____| _____
_____|_____|_____| _____