Medical History

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of primary physician: _____ Phone #_____

Do you take a **PreMed** for dental treatment? ☐ Yes ☐ No Reason _____

Previous dentist: _____ Phone #_____

Date of last dental visit: _____ Date of last dental x-rays: _____

Have you ever had complications during or following dental treatment? ☐ Yes ☐ No

Please Explain: _____

Are you allergic to the following medications: ☐ Penicillin ☐ Codeine ☐ Novocaine ☐ Other

Other Medication Allergies: _____

Are you currently taking Blood Thinners (such as Coumadin, Plavix, Xarelto, etc.)? ☐ Yes ☐ No

Have you ever taken bisphosphonates for osteoporosis or bone disorders? ☐ Yes ☐ No

Do you Smoke or use Tobacco? ☐ Yes ☐ No

Have you ever had any of the following:

Allergies ☐ Yes ☐ No What kind:_____

Anemia ☐ Yes ☐ No

Artificial Heart Valves ☐ Yes ☐ No

Artificial Joints ☐ Yes ☐ No When placed:_____

Asthma ☐ Yes ☐ No Last time inhaler used:_____

Bleeding Gums ☐ Yes ☐ No

Blood Disease ☐ Yes ☐ No Type_____

Cancer ☐ Yes ☐ No Type_____ Diagnosis Date _____

Chemo or Radiation ☐ Yes ☐ No Date_____

Diabetes ☐ Yes ☐ No Typical Blood Sugar: <100 100-150 150-250 >250

Dizziness/Fainting ☐ Yes ☐ No

Defibrillator ☐ Yes ☐ No

Epilepsy ☐ Yes ☐ No

Excess Bleeding ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No

Head Injuries ☐ Yes ☐ No

Heart Murmur ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No Type: ☐ A ☐ B ☐ C ☐ Other

Please Turn Page Over…

Medical History

High Blood Pressure ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Jaundice/Liver Disease ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Mental Disease ☐ Yes ☐ No
Nervous Disorders ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Pregnant (current) ☐ Yes ☐ No
Radiation ☐ Yes ☐ No When & Where:_____
Respiratory Problems ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No When:_____
Sinus Problems ☐ Yes ☐ No
Stomach Problems ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Thyroid Problems ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No When:_____
Ulcers ☐ Yes ☐ No
Venereal Disease ☐ Yes ☐ No
Other: _____

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

Medication	Reason for medication	Dosage&Frequency

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health or medication, I will inform the Doctors at my next appointment.

X_____Date _____
Signature of Patient, Parent, or Guardian

Medical History Updated:

Date:	Patient Initials:	Staff Initials:	UPDATES: