

Medical History

Last Name*: _____ First Name*: _____ Birthdate*: _____

Date: _____

Medical Doctor Information

Have you been under the care of a medical doctor during the past two years? * Y N

If YES, for what _____

Name of Medical Doctor: _____ Phone: _____

Address: _____ City _____ State: _____ Zip: _____

Preferred Pharmacy

Preferred Pharmacy Location: _____

Medications

Are you currently taking any medications or drugs? * Y N

If YES, please list all including OTC, vitamins, and herbal supplements

_____	_____
_____	_____
_____	_____
_____	_____

Allergies

Are you allergic to any of the following? Please check all that apply.

- | | | | |
|----------------------------------|--------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Metal |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Codeine | <input type="checkbox"/> NSAIDS | <input type="checkbox"/> Penicillin |

Others? If YES, please list: _____

Medical History

Do you have, or have you had, any of the following? Please check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Angina/Chest Pains | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Heart Pacemaker/Defibrillator | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Stomach/Intestinal Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes / A1C: _____ Date: _____ | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Use of Tobacco/Vape |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Venereal Disease |

Have you ever had any serious illness not listed above?* Y N

If YES, please list: _____

Medical Questions

Are you, or have you ever been prescribed any pre-medicated antibiotics prior to dental treatment?* Y N

Are you currently taking anti-coagulants or blood thinners?* Y N

Have you ever had any abnormal bleeding following dental extractions, surgery, or a cut?* Y N

Have you ever been exposed to hepatitis, HIV, or any sexually transmitted diseases?* Y N

Have you ever taken medications, injections, or infusions for bone density or any other medical condition (medications such as Bisphosphonates, Alendronate, Fosamax, Prolia, Reclast, Denosumab etc.)?* Y N

Have you ever been hospitalized or had a major operation?* Y N

If YES, please list: _____

Dental History

What is your dental concern?* _____

Are you having pain or discomfort?* Y N

If YES, where? _____

Questions for Women

Women: Are you pregnant or trying to get pregnant Y N

Women: Are you nursing Y N

Women: Do you take oral contraceptives? Y N

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.

Patient, Parent or Guardian Signature