# MEDICAL HISTORY

Name_____ Age _____ Birthdate _____

Physician's Name _____ Phone _____

Physician's Address/ location _____

Are you currently under the care of a physician? Yes _____ No_____

If Yes, for what reason? _____

**Please list all medications that you are taking in the box to the right** ⇨ ⇨ ⇨

Have you ever taken prescription drugs for weight loss (i.e. PhenFen or Redux) Yes ___ No___

Have you ever taken medications for Osteoporosis (i.e. Fosamax, Aredia,Boniva) Yes___ No ___

Are you, or have you ever taken any "Blood Thinners" (i.e. Coumadin, Plavix, Xarelto, Pradaxa) Yes ___ No___

Do you currently, or have you had to, take antibiotics before dental treatment? Yes ___ No ___

**ALLERGIES:**

Are you allergic (or have had an adverse reaction) to: Check all that apply

Penicillin_____ Codeine _____ Local Anesthetic _____ Latex _____ None _____

Other medications or substances _____

Have you had any unusual or unexplained reactions during a surgical procedure? Yes ____ No ____

If yes, please explain_____

Hearing impaired? Yes _____ No _____

**List of all medications: including over the counter medications; vitamins and supplements:**

_____

_____

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**Do you have any of the following: (Yes or No)**

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Heart Disease/Surgery | ☐ | ☐ | Asthma | ☐ | ☐ | Artificial Joint | ☐ | ☐ | Hepatitis (A / B/ C) | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ | Shortness of Breath | ☐ | ☐ | Prosthetic Implants | ☐ | ☐ | Blood Transfusion | ☐ | ☐ |
| Heart pacemaker | ☐ | ☐ | Respiratory Ailments | ☐ | ☐ | Cancer | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Tuberculosis | ☐ | ☐ | Radiation Therapy | ☐ | ☐ | Stomach Disorders | ☐ | ☐ |
| Rheumatic Heart Disease | ☐ | ☐ | Sinus Trouble | ☐ | ☐ | Chemotherapy | ☐ | ☐ | Organ Transplant | ☐ | ☐ |
| Congenital Heart Disease | ☐ | ☐ | Chronic Cough | ☐ | ☐ | Prolonged Bleeding | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Artificial Heart Valve | ☐ | ☐ | Thyroid problem | ☐ | ☐ | Leukemia | ☐ | ☐ | Steroid use | ☐ | ☐ |
| Mitral Valve Prolapse | ☐ | ☐ | Kidney problems | ☐ | ☐ | Blood Disorder | ☐ | ☐ | Arthritis/Rheumatism | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ | Hemophilia | ☐ | ☐ | Neurological Disorder | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | HIV positive/AIDS/ARC | ☐ | ☐ | Anemia | ☐ | ☐ | Epilepsy | ☐ | ☐ |
| Sleep Disorders | ☐ | ☐ | Stroke | ☐ | ☐ | GERD | ☐ | ☐ | Osteoporosis | ☐ | ☐ |
| Sleep Apnea | ☐ | ☐ | Fainting Spells | ☐ | ☐ | Removal of Spleen | ☐ | ☐ | Botox/Cosmetic Filler | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Anorexia/Bulimia | ☐ | ☐ | Liver Disease | ☐ | ☐ | Substance abuse/Alcoholism | ☐ | ☐ |

Do you have a condition that is not listed that we should be aware of? If yes please note: _____

DR. COMMENTS:
PREMEDICATION REQUIRED ☐

Do you currently smoke or use the following tobacco products?

Cigarettes ___ Packs /Day? _____ Cigars ___ Pipe ___ Chew ___ None___

Have you used tobacco products in the past? Yes ___ No ___ If yes, how long ago? _____

Have you had any serious illness, hospitalization or accident? Yes _____ No_____

If yes, please explain _____

**Women:**
Are you pregnant? Yes___ No ___
Are you taking contraceptives?Yes _ No _
If yes please note
_____

I understand the above information is necessary to provide me with dental care in a safe and efficient matter. I have answered all questions to the best of my knowledge. Should further information be needed you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify this doctor of my changes in my health or medication.

**Patient's Signature**_____ **Date** _____

(Signature of Parent or Guardian if a minor)