Medical History

PATIENT NAME (PRINT)

Date of Birth:

Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health Problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
1 Are you in good health?	☐	☐
2 Have there been any changes in your general health within the past year?	☐	☐
3 Date of your last physical exam_____		
4 Physicians Name_____ Phone #_____		
5 Do you routinely see an MD?	☐	☐
6 Have you ever been hospitalized for any surgical operation or serious illness? Please explain._____	☐	☐
7 Are you taking any medicine, include non-prescription medicine? If yes, please provide a separate list or list here:	☐	☐
8 Have you had any abnormal bleeding?	☐	☐
9 Have you ever had a blood transfusion?	☐	☐
10 Have you ever taken Fen-Phen/Redux?	☐	☐
11 Have you ever taken Fosamax, Boniva, Actonel, or medications containing Bisphosphonates?	☐	☐
12 Have you taken Viagra, Revatio, Cialis, or Levitra?	☐	☐
13 Do you use tobacco?	☐	☐
14 Do you or have you use controlled substances in the last 12 hours?	☐	☐
15 Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
16 Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐
Women only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

	YES	NO
Are you allergic to or been told not to take:	☐	☐
Local anesthetics	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Aspirin/ ibuprofen or tylenol	☐	☐
Iodine	☐	☐
Any metals (e.g. - Nickel)	☐	☐
Latex / Rubber		
Other (please list)_____		
Do you have or have you had the following:	☐	☐
ADHD/Learning Disability/ Autism	☐	☐
AIDS or HIV Infection	☐	☐
Allergies: Seasonal/Hay fever	☐	☐
Anemia/Low iron	☐	☐
Anxiety: Dental (moderate to severe)	☐	☐
Anxiety: General (moderate to severe)	☐	☐
Arthritis	☐	☐
Asthma or breathing problems	☐	☐
Back Problems	☐	☐
Cancer: _____	☐	☐
Chemical Dependency (past or current)	☐	☐
Chemotherapy (cancer)	☐	☐
Chest Pain	☐	☐
Cold Sores	☐	☐
COPD	☐	☐
Cortisone treatments	☐	☐
Cough that produces blood or Tuberculosis (TB)	☐	☐
Diabetes/High Blood Sugar	☐	☐
Dry mouth/Xerostomia/Sjogren's	☐	☐
Eating disorders	☐	☐
Epilepsy/seizures	☐	☐
Fainting or dizzy spells/vertigo	☐	☐
Fibromyalgia	☐	☐
Glaucoma	☐	☐
Heart: Defect or heart murmur	☐	☐
Heart: Atrial fibrillation	☐	☐
Heart: Congenital Heart Problems	☐	☐
Heart: Congestive Heart Failure	☐	☐
Heart: Heart Attack, or Angina	☐	☐
Heart: Mitral Valve Prolapse	☐	☐
Heart: Pacemaker or defibrillator	☐	☐
Heart: Rheumatic Heart Disease or Rheumatic Fever	☐	☐
Hepatitis B, Jaundice, Liver Disease or Hepatitis C	☐	☐
High/Low Blood Pressure	☐	☐
High Cholesterol	☐	☐
Hives or Skin Rash	☐	☐
Hypoglycemia (low blood sugar)	☐	☐
IBS: Irritable Bowel Syndrome	☐	☐
Joint replacement: _____ Date of sx_____	☐	☐
Kidney issues	☐	☐
Leukemia	☐	☐
Lung Problems/Cancer	☐	☐
Lupus	☐	☐
Lyme Disease	☐	☐
Memory issues/Dementia:_____	☐	☐
Mental health care	☐	☐
Migraine headaches	☐	☐
Multiple Sclerosis/ Parkinsons	☐	☐
Osteoporosis	☐	☐
Persistent Cough	☐	☐
Prostate issues/cancer	☐	☐
Radiation Therapy	☐	☐
Scarlet Fever	☐	☐
Sexually Transmitted Disease	☐	☐
Swelling of feet, ankles, or hands or shortness of breath	☐	☐
Sinus Trouble	☐	☐
Sleep Apnea/ C-PAP	☐	☐
Stomach ulcer/Acid Reflux	☐	☐
Stroke	☐	☐
Thyroid issues	☐	☐
Tonsillitis	☐	☐
Tumors		

Patient Signature