Medical History

Patient Name _____

WELCOME, *Please take the time to complete this form with your current medical information. You, and your families medical history will influence your susceptibility to certain dental conditions. The following information should be as complete and accurate as possible as we use it to select the most appropriate dental care for you. Please inform us of any changes to your medical history in the future.*

Physician's Name _____ Physician's Address _____

Date of your last medical physical:_____ Are you currently under the care of a physician? Y / N
Why?_____

Do you or have you had any of the following conditions:

❑Yes ❑No Abnormal Bleeding
❑Yes ❑No Anemia/Blood disorders
❑Yes ❑No Any heart problems
❑Yes ❑No Arthritis/Rheumatism
❑Yes ❑No Artificial Heart Valve Implant
❑Yes ❑No Asthma/Hay fever
❑Yes ❑No Blood Pressure Problems: High / Low
❑Yes ❑No Cancer, Type:
❑Yes ❑No Difficulty Breathing
❑Yes ❑No Epilepsy or Seizures
❑Yes ❑No Fainting or Dizzy Spells
❑Yes ❑No Frequent Headaches, shoulder or neck aches
❑Yes ❑No Glaucoma or light sensitivity
❑Yes ❑No Heart murmur
❑Yes ❑No Diabetes: Type 1 or Type 2
Date Diagnosed_____ Controlled or Uncontrolled? By Medication or Diet?
❑Yes ❑No Hepatitis, Type:
❑Yes ❑No Herpes/Cold Sores/Shingles
❑Yes ❑No Kidney/Liver Problems
❑Yes ❑No Mental/Emotional Disorders
❑Yes ❑No Nervous Problems
❑Yes ❑No Organ Transplant, Type:
❑Yes ❑No Osteoporosis
❑Yes ❑No Prosthetic Joint Replacement Date:
❑Yes ❑No Radiation or Chemotherapy Why:
❑Yes ❑No Rheumatic Fever
❑Yes ❑No Sinus Problems
❑Yes ❑No Stomach Problems
❑Yes ❑No Stroke
❑Yes ❑No Tested Positive for HIV
❑Yes ❑No Thyroid: Hypothyroid/Hyperthyroid

Have you ever taken Bisphosphonates such as Actonel, Boniva, Didronel, or Fosamax? Y /N If yes, what:_____
Have you ever taken any prescription weight loss products? Y / N If yes, what:_____
Have you ever had a serious illness or major surgery not listed above? Y / N *If yes, please explain:* _____
_____

Is there a family history of Diabetes, Heart Disease, Oral Cancer, or Periodontal Disease? Y / N *If yes, please explain:*
_____

Would you describe your stress level as high, average, or low? *Circle one.*
Do you smoke, vape, chew, use snuff, or any other forms of tobacco? Y / N *Circle those that apply.*
How long have you used tobacco? _____ *How much do you use?* _____
Have you ever quit or thought about quitting? _____ *Are you interested in quitting?*_____

Please list any medications you are currently taking,
Include prescription and non-prescription:

List any health related substances you take routinely.
Include any vitamins, supplements, or natural products.

Yes / No	List All Allergies
☐ ☐	Latex
☐ ☐	Penicillin
☐ ☐	Sulfa
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Jewelry or metals

Other:_____
_____

If female, please answer the following:
Are you taking Birth Control Pills? Y/ N
Are you pregnant? Y / N If Yes, # of weeks_____
Are you nursing? Y / N

I certify that the above information is complete and accurate.
Patient/Guardian Signature_____ Date:_____
Dentist's Initials_____ Date:_____