## **Medical History**

Dentist's Initials\_

\_\_\_\_\_ Date:\_\_

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	
Date of your last medical physical: Are you curren 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 Heart murmur Yes No Diabetes: Type 1 or Type 2  Date Diagnosed Controlled or U	
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?  Do you smoke, vape, chew, use snuff, or any other forms of tob.  How long have you used tobacco?  Have you ever quit or thought about quitting?	pacco? Y / N Circle those that apply. How much do you use?
Please list any medications you are currently taking, Include prescription and non-prescription:	Yes / No List All Allergies  Latex Penicillin Sulfa Aspirin Codeine Dental Anesthetics Jewelry or metals Other:
List any health related substances you take routinely.	
Include any vitamins, supplements, or natural products.	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: