**Medical History and Information**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Medical Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date and Reason of last visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle Yes (Y) or No (N) along with the date if you have or have ever had any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Y N Abnormal Bleeding Y N Acid Reflux Y N Alcohol Use/Abuse  Y N Alzheimer’s Disease  Y N Anaphylaxis  Y N Anemia  Y N Angina Pectoris  Y N Arthritis  Y N Artificial Heart Valve  Y N Blood Transfusion  Y N Bruise Easily  Y N Cancer  Y N Chemotherapy  Y N Chest Pain  Y N Cold Sores/Fever Blisters  Y N Congenital Heart Defect | Y N Congestive Heart Failure  Y N Convulsions  Y N Cortisone Medicine  Y N Diabetes I or II  Y N Difficulty Breathing  Y N Drug Use/Abuse  Y N Eating Disorder  Y N Endocarditis  Y N Emphysema  Y N Epilepsy  Y N Facial Surgery  Y N Fainting Spells  Y N Frequent Headaches  Y N Glaucoma  Y N Genital Herpes  Y N Hay Fever | Y N Heart Attack  Y N Heart Disease  Y N Heart Surgery  Y N Heart Murmur  Y N Hemophilia  Y N Hepatitis A, B, or C  Y N High Blood Pressure  Y N HIV/AIDS  Y N Hives/Rash  Y N Joint Replacement  Y N Kidney Problems  Y N Liver Disease  Y N Low Blood Pressure  Y N Mitral Valve Prolapse  Y N Pace Maker  Y N Pain in Jaw Joints | Y N Psychiatric Treatment  Y N Radiation Therapy  Y N Rheumatic Fever  Y N Rheumatism  Y N Seasonal Allergies  Y N Seizures  Y N Sexually Transmitted Disease  Y N Sickle Cell Disease  Y N Sinus Problems  Y N Steroid Treatment  Y N Stroke  Y N Thyroid Disease  Y N Tobacco Use  Y N Tuberculosis  Y N Ulcers  Y N Unexplained Weight Loss |

Any current or history of other condition not listed above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all current medications and dosages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking in blood thinning medications? (ie. Coumadin, Warfarin, Plavix, Aspirin…)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently or have you ever taken any bisphosphonates for osteoporosis? (ie Actonel, Boniva, Fosamax, Didronal, Risedronate, IV therapy…) If yes, please list name, dose, and date taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any of the following? If yes, please check and explain reaction:

Aspirin **Latex** Iodine Metals Sulfa Drugs Benzodiazepines

**Penicillin** Cephalosporins Local Anesthetics Dyes **Amoxicillin**

Other Known Allergies (including to any to other medications): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized or had any major surgeries, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Female Patients: Are you pregnant?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If yes, what is your due date?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you nursing?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you taking birth control pills?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have answered the above health history questions truthfully and to the best of my knowledge. I understand this information is important in order to receive dental care in the safest possible manner.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_