

Medical History

Patient's Name _____ Date of Birth _____

Medical Doctor _____ Telephone: _____

Do you presently have or have you had	Yes	No	<u>Official Use Only</u>
1. May I have permission to consult your physician if necessary?.....	O	O	
2. Are you taking any medication drugs, over the counter or herbal Supplements?	O	O	
(PLEASE LIST ON THE BACK SIDE OF THIS FORM)	O	O	
3. Are you allergic to any medication or Latex?.....	O	O	
Please List _____			
4. Do you need to take an antibiotic pre-medication before dental treatment?.....	O	O	
5. AIDS/HIV.....	O	O	
6. Anemia.....	O	O	
7. Arthritis.....	O	O	
8. Bleeding Disorder.....	O	O	
9. Bone Disorder.....	O	O	
10. Breathing Difficulties (asthma, emphysema, hay fever, or sinus problem)?.....	O	O	
11. Cancer or other tumors	O	O	
12. Chemo or Radiation Therapy.....	O	O	
13. Diabetes O Type 1 O Type 2	O	O	
14. Do you or have you ever taken Bisphosphonates?	O	O	
15. Do you use alcohol, tobacco or smokeless tobacco?.....	O	O	
16. Do you use recreational drugs?.....	O	O	
17. Drug or Alcohol Addiction.....	O	O	
18. Glaucoma	O	O	
19. Heart Disease, heart attack, heart murmur, heart valve replacement or pacemaker.....	O	O	
20. Hepatitis.....	O	O	
21. High/Low Blood Pressure.....	O	O	
22. Hypoglycemia.....	O	O	
23. Joint Replacement, Shunt or Stint Placemen.....	O	O	
24. Kidney Disease or Liver Disease.....	O	O	
25. Mental illness, depression, epilepsy (seizure), fainting or dizzy spells?	O	O	
26. Rheumatic Fever.....	O	O	
27. Stroke	O	O	
28. Thyroid Disorder.....	O	O	
29. Tuberculosis	O	O	
30. Stomach problems, ulcers, irritable bowel, or acid reflux (GERD)	O	O	
31. Venereal Disease (Syphilis, Gonorrhea, Herpes, etc.)	O	O	
32. Have you ever had any serious illness not listed above?.....	O	O	

Women:

1. Are you currently pregnant?	O	O	
2. Are you currently using a prescription-type contraceptive?	O	O	

Consent:

To the best of my knowledge all of the proceeding health history answers are true and correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at my next appointment.

Signature: _____ Relationship to Patient: _____

Reviewing Doctor _____ Date: _____

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	Medications	Dose/Frequency	Reason For Taking
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			