Medical History Form

Patient Name: ______________________________ Birth Date: ______________________________

Name of Physician: ______________________________ Physician Phone # ______________________________

Are you allergic to or had an allergic reaction to:

Aspirin, Ibuprofen, Acetaminophen, Codeine (circle)	**Y N**
Penicillin, Augmentin, Keflex, Erythromycin (circle)	**Y N**
Tetracycline, Sulfa, Bactrim (circle)	**Y N**
Local anesthetics	**Y N**
Fluoride	**Y N**
Metals: Nickel, Gold, Silver (circle)	**Y N**
Latex	**Y N**
Other: ______________________________	

Do You Have or Have You Ever Had:

Heart attack or Cardiac stent (circle)	**Y N**
Infective endocarditis	**Y N**
Artificial heart valve or Heart defect repair (circle)	**Y N**
Pacemaker or Implantable defibrillator (circle)	**Y N**
Did any of the above occur within the last 6 months?	**Y N**
Heart murmur or Mitral valve prolapse (circle)	**Y N**
Congenital heart defect or Congestive heart failure	**Y N**
Rheumatic or Scarlett fever (circle)	

Do You Take or Have You Ever Taken:

Premedication (antibiotics) prior to dental appointment	**Y N**
Antidepressants or Anti-anxiety meds (circle)	**Y N**
Bisphosphonates (osteoporosis, Paget's disease)	**Y N**
Fen-phen (weight management)	**Y N**

High cholesterol	**Y N**
Do you take statin drugs?	**Y N**
High or Low blood pressure (circle)	**Y N**
Stroke	**Y N**
Are you taking blood thinners?	**Y N**
Anemia or Hemophilia (circle)	**Y N**
Vitamin B12 deficiency	**Y N**
Blood transfusion	**Y N**
Prolonged bleeding (INR >3.5)	**Y N**

Do You Have or Have You Ever Had:

Kidney disease	**Y N**
Liver disease or Jaundice (circle)	**Y N**
Hepatitis, if yes: Type A, B, C (circle)	**Y N**
Diabetes, if yes: Type ____ HbA1c = ____	**Y N**
Thyroid disease or Autoimmune disease (circle)	**Y N**
Gastrointestinal disease	**Y N**
Reflux or Heartburn or Ulcers (circle)	**Y N**
Arthritis or Rheumatoid arthritis (circle)	**Y N**
Lupus erythematous	**Y N**
Malignant Hypothermia	**Y N**
Osteoporosis or Osteopenia (circle)	**Y N**
Joint Replacement, if yes: Type ________________	**Y N**
Viral infection or Cold Sore (circle)	**Y N**
Tumors, if yes: Where ______________________	**Y N**
Cancer, if yes: Type ______________________	**Y N**
Chemotherapy or Radiation (circle)	**Y N**
HIV / AIDS	**Y N**
Sexually Transmitted Disease	**Y N**

Emphysema or COPD or Asthma (circle)	**Y N**
Tuberculosis or Sarcoidosis (circle)	**Y N**
Shortness of breath	**Y N**
Sleep apnea or Snoring (circle)	**Y N**
Sinus trouble	**Y N**
Glaucoma or Contact lenses	**Y N**
Tobacco use: Smoking, Snuff, Chew (circle)	**Y N**
Alcohol or Controlled substance use (circle)	**Y N**

Head or Neck injury (circle)	**Y N**
Neurologic disorders, Epilepsy or Migraines (circle)	**Y N**
Alzheimer's disease or Dementia (circle)	**Y N**
Parkinson's disease	**Y N**
Fibromyalgia or Cerebral Palsy (circle)	**Y N**
Psychiatric treatment	**Y N**
Vertigo	**Y N**

List all medications, supplements and vitamins you are currently taking:

Drug	**Purpose**	**Drug**	**Purpose**
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient or Parent/Guardian's Signature: ______________________________ Date: ____________________