# MEDICAL HISTORY

Patient Name: 0000 (First) 0000 (Last) Birthday: 01/01/0001

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following:

Are you ALLERGIC to any of the following?
(Please check Y for yes or N for no)

- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Ibuprofen/Advil/Motrin
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Latex
- ☐ Other: _____

List Reaction: _____

Please list all MEDICATIONS you are taking:
(prescription & over the counter medications)

Medication: Do you currently take any medications? ☐ Y ☐ N
If yes, please list below:

_____

Physician's Name: _____ Phone: _____

Address: _____ Fax: _____

Do you have or have you had any of the following? (Please check Y for yes or N for no)

| Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Heart Disease | ☐ | ☐ | Ulcers | ☐ | ☐ | Thyroid Disease |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Liver Disease | ☐ | ☐ | Tumor |
| ☐ | ☐ | Heart Murmur | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Cancer/ Chemotherapy |
| ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Jaundice | ☐ | ☐ | Radiation Therapy |
| ☐ | ☐ | Congenital Heart Lesions | ☐ | ☐ | Hepatitis A | ☐ | ☐ | Epilepsy/ Seizures |
| ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | Hepatitis B or C | ☐ | ☐ | Fainting Spells |
| ☐ | ☐ | Implants/Artificial Joints | ☐ | ☐ | HIV/AIDS | ☐ | ☐ | Glaucoma |
| ☐ | ☐ | Stroke | ☐ | ☐ | Cold sores/ Fever Blisters | ☐ | ☐ | Diabetes - Type: _____ |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Herpes | ☐ | ☐ | Heart Attack/Failure- Date: _____ |
| ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | STD/Venereal Diseases | ☐ | ☐ | History of Drug Addiction |
| ☐ | ☐ | Anemia | ☐ | ☐ | Infectious Mononucleosis | ☐ | ☐ | History or Emotional or Nervous Disorders |
| ☐ | ☐ | Prolonged Bleeding Disorder | ☐ | ☐ | Immune Suppressed Disorder | ☐ | ☐ | Smoker? _____yrs. _____cigs/ day |
| ☐ | ☐ | Tuberculosis or Lung Disease | ☐ | ☐ | Hearing Loss | ☐ | ☐ | Quit smoking? _____yrs ago |
| ☐ | ☐ | Asthma | ☐ | ☐ | Excessive Urination | | | |
| ☐ | ☐ | Hay Fever | ☐ | ☐ | Excessive Thirst | | | |
| ☐ | ☐ | Sinus Trouble | ☐ | ☐ | Recent Weight Gain/ Loss | | | |
| ☐ | ☐ | Headaches/Migranes | | | | | | |

WOMEN:

| Y | N | |
|---|---|---|
| ☐ | ☐ | Are you or could you be pregnant or nursing? |
| ☐ | ☐ | Are you taking birth control medication? |

| Y | N | |
|---|---|---|
| ☐ | ☐ | Have you ever had major surgery? Year & description: _____ |
| ☐ | ☐ | Have you ever taken the medication Fen-Phen? ☐ Y ☐ N or Redux? ☐ Y ☐ N or bisphosphonates (Fosamax)? |
| ☐ | ☐ | I usually take an antibiotic prior to dental treatment. |
| ☐ | ☐ | I chew tabacco. _____yrs. How often? _____ |
| ☐ | ☐ | Do you have any other medical problem NOT listed on this form? list: _____ |

In the event of an EMERGENCY, please CONTACT:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

**To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, or address changes, I will inform the dental office.

01/16/2020

SIGNATURE of Patient, Parent, Guardian DATE Doctor's SIGNATURE