

**Patient Name** \_\_\_\_\_ **Medical History** \_\_\_\_\_ **Date** \_\_\_\_\_

Are you under a physician's care now? If yes, why? \_\_\_\_\_ Yes No

Who is your physician? \_\_\_\_\_ Phone # \_\_\_\_\_

Have you ever been hospitalized or had a major operation? Discuss \_\_\_\_\_ Yes No

Have you ever had a serious injury to your head or neck? Discuss \_\_\_\_\_ Yes No

Are you on a special diet? Discuss \_\_\_\_\_ Yes No

Are you taking and medications, aspirin, vitamins, herbals, pills or drugs? What? \_\_\_\_\_ Yes No

Are you taking any blood thinners? \_\_\_\_\_ Yes No

Are you allergic to any medications or substances? If yes, please check item below:

\_\_\_\_\_ Aspirin \_\_\_\_\_ Penicillin \_\_\_\_\_ Codeine \_\_\_\_\_ Acrylic \_\_\_\_\_ Metal \_\_\_\_\_ Milk \_\_\_\_\_ Other

Women: (please check) \_\_\_\_\_ Pregnant/trying to get pregnant \_\_\_\_\_ Nursing \_\_\_\_\_ Taking oral contraceptives

**Do you now have or have you ever had any of the following? Please check appropriate Answer. If you answer "yes" to any of the conditions, please call prior to your appointment as premedication or changes in medication may be required. YES NO**

\*\*\*\* DO YOU NEED A PRE-MEDICATION YES / NO \*\*\*\* What is your preferred pharmacy \_\_\_\_\_

Please read carefully and check mark if you have any of these conditions:

- |   |  |  |   |  |
|---|--|--|---|--|
| <input type="checkbox"/> Allergies (Medicines)    | <input type="checkbox"/> BLOOD THINNERS                | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Liver Disease                | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Allergies(dust/pollen)   | <input type="checkbox"/> Bruise Easily / Blood Disease | <input type="checkbox"/> Heart Disease/ Surgery  | <input type="checkbox"/> Breathing problems           | <input type="checkbox"/> Sinus Trouble       |
| <input type="checkbox"/> Alzheimer's Disease      | <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Pulmonary Shunt              | <input type="checkbox"/> Sleep Apnea         |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> X-ray Treatment (Radiation)   | <input type="checkbox"/> Coronary Stent          | <input type="checkbox"/> Shortness of Breath          | <input type="checkbox"/> Stomach/Intestinal  |
| <input type="checkbox"/> Angina/Chest pain        | <input type="checkbox"/> Chemotherapy                  | <input type="checkbox"/> Heart Attack/ Failure   | <input type="checkbox"/> Nervousness                  | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Artificial Joint*        | <input type="checkbox"/> Cold Sores/ Herpes            | <input type="checkbox"/> Heart Murmur/Defect*    | <input type="checkbox"/> Pain in Jaw Joints           | <input type="checkbox"/> Swelling of limbs   |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Congenital Heart Disorder     | <input type="checkbox"/> Heart Pacemaker*        | <input type="checkbox"/> Thyroid Disease              | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Arthritis/ Gout          | <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> High Blood pressure     | <input type="checkbox"/> Psychiatric Care             | <input type="checkbox"/> Tumors or Growths   |
| <input type="checkbox"/> Bacterial Endocarditis*  | <input type="checkbox"/> Drug Addiction/Alcoholism     | <input type="checkbox"/> Irregular heart beat    | <input type="checkbox"/> Renal Dialysis               | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Bisphosphonates          | <input type="checkbox"/> Emphysema                     | <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Rheumatism                   | <input type="checkbox"/> Unexplained Fever   |
| <input type="checkbox"/> Aredia I.V. Reclast I.V  | <input type="checkbox"/> Epilepsy or Seizures          | <input type="checkbox"/> Mitral Valve Prolapse*  | <input type="checkbox"/> Sexually Transmitted Disease |  |
| <input type="checkbox"/> Fosamax, Actonel, Boniva | <input type="checkbox"/> Excessive Bleeding            | <input type="checkbox"/> Rheumatic Fever*        | <input type="checkbox"/> AIDS                         | <input type="checkbox"/> Genital Herpes      |
| <input type="checkbox"/> Osteonecrosis of jaw     | <input type="checkbox"/> Fainting or Dizziness         | <input type="checkbox"/> Scarlet Fever           | <input type="checkbox"/> Hepatitis A (infectious)     | <input type="checkbox"/> Hepatitis B or C    |
| <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Zometa I.V.                   | <input type="checkbox"/> Frequent Cough          | <input type="checkbox"/> Hemophilia                   | <input type="checkbox"/> HIV Positive        |

Have you ever had any other serious illness not checked above? Discuss \_\_\_\_\_ Yes / No

Do you wish to talk to the dentist privately about any problem? \_\_\_\_\_ Yes / No

**To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicine changes, I shall inform the dentist and staff at the next appointment without fail.**

X \_\_\_\_\_ Date \_\_\_\_\_

**Patient Signature** (Parent or guardian)

Reviewed by Doctor \_\_\_\_\_ Date \_\_\_\_\_

History Review and Significant Findings \_\_\_\_\_

Medical Updates

I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions. Sing and date below.

Date	Exceptions, NEW TO REPORT	No change	Patient's Signature	Reviewed by:
_____	_____	_____	_____	Dr. _____
_____	_____	_____	_____	Dr. _____
_____	_____	_____	_____	Dr. _____
_____	_____	_____	_____	Dr. _____
_____	_____	_____	_____	Dr. _____

