Medical History Form - updated - 10/16/17 revised 10 31 17 * 5/19

Patient Name: Birth Date: Date Created:

Are you currently receiving care with a primary care physician?	Yes No	If yes	
Have you been hospitalized? Had a major operation? Had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you take, or have you taken Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No		
Do you use controlled substances?	Yes No	If yes	
Do you use tobacco?	Yes No	If yes	
Women: are you - pregnant/trying to get pregnant? Taking oral contraceptives? Nursing?	Yes No	If yes	
Do you currently take a pre-medication prior to dental treatment?	Yes No	If yes	
Do you have a dental anxiety?	Yes No	If yes	

Are you allergic to ?

Sulfa	Yes	No
Latex	Yes	No
Amoxicillin	Yes	No

Other Allergies? Yes No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No	Alzheimer's Disease	Yes No
Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No	Anaphylaxis	Yes No
Drug Addiction	Yes No	Hepatitis B or C	Yes No	Anemia	Yes No	Rheumatic Fever	Yes No
Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No	Arthritis/Gout	Yes No
Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No	Artificial Heart Valve	Yes No
Excessive Bleeding	Yes No	Shingles	Yes No	Artificial Joint	Yes No	Asthma	Yes No
Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No	Blood Disease	Yes No
Frequent Cough	Yes No	Kidney Problems/Disease	Yes No	Blood Transfusion	Yes No	Stomach/Intestinal Problems	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No		
Bruise Easily	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No	Stroke	Yes No
Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No	Cancer/Leukemia	Yes No
Mitral Valve Prolapse	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Chemotherapy	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Tumors or Growths	Yes No	Tuberculosis	Yes No
Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No	Congenital Heart Disorder	Yes No
Psychiatric Care	Yes No	Venereal Disease	Yes No	Yellow Jaundice	Yes No	Heart Trouble/Disease	Yes No

Have you ever had any serious illness not listed above? Yes No If yes

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, c
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my re

NO CHANGES in medical history since last visit! ☐

Signature of Patient, Parent or Guardian:

X Date:_____