Medical History

Patient Name _____ **Birthdate:** _____

WELCOME, *Please take the time to complete this form with your current medical information. Your medical history history contributes to and influences the dental care recommendations we make. Please inform us of any changes to your medical history in the future. Thank you!*

Physician's Name _____ Physician's Address _____

Date of your last medical physical:_____ Are you currently under the care of a physician? Y / N
Why?_____

Have you traveled outside the USA in the last month? ❑Yes ❑No If yes, where? _____

Please check any of the following conditions that you have or have had in the past:

❑Yes ❑No Acid Reflux, or GERD
❑Yes ❑No Alzheimer's or Dementia
❑Yes ❑No Anemia, Blood Disorders, Abnormal Bleeding
❑Yes ❑No Arthritis, Rheumatism, or Gout
❑Yes ❑No Artificial Heart Valve, Implant, or Pacemaker
❑Yes ❑No Asthma
❑Yes ❑No Autoimmune Disease, Type:
❑Yes ❑No Blood Pressure Problems: High / Low
❑Yes ❑No Cancer, Type:
❑Yes ❑No Cold Sores or Canker Sores
❑Yes ❑No COPD, Emphysema, or Difficulty Breathing
❑Yes ❑No Diabetes: Type 1 or Type 2
❑Yes ❑No Epilepsy or Seizures
❑Yes ❑No Fainting or Dizzy Spells
❑Yes ❑No Frequent Headaches, Shoulder or Neck Aches
❑Yes ❑No Glaucoma or Light Sensitivity
❑Yes ❑No Hay Fever or Sinus Problems
❑Yes ❑No Heart Attack or Heart Problems
❑Yes ❑No Heart Murmur
❑Yes ❑No Hepatitis, Type:
❑Yes ❑No High Cholesterol
❑Yes ❑No Kidney or Liver Disease
❑Yes ❑No Mental or Emotional Disorders
❑Yes ❑No Mitral Valve Prolapse
❑Yes ❑No Nervous System Diseases or Problems
❑Yes ❑No Organ Transplant, Type:
❑Yes ❑No Osteopenia or Osteoporosis
❑Yes ❑No Prosthetic Joint Replacement Date:
❑Yes ❑No Radiation or Chemotherapy Why:
❑Yes ❑No Rheumatic Fever
❑Yes ❑No Sleep Apnea
❑Yes ❑No STD's: HPV, Venereal Disease, Other
❑Yes ❑No Stroke
❑Yes ❑No Tested Positive for HIV
❑Yes ❑No Thyroid: Hypothyroid or Hyperthyroid
❑Yes ❑No Tuberculosis

Do you have other health conditions or had major surgery not listed above? Y / N I*f yes, explain* : _____
_____

Have you ever taken Bisphosphonates such as Actonel, Boniva, Reclast, or Fosamax? *If yes, what*_____

Have you taken the prescription weight loss drugs Fen-Phen or Redux? Y / N *If yes, what* _____

Is there a family history of Diabetes, Heart Disease, Oral Cancer, or Periodontal Disease? *Circle those that apply.*

Would you describe your stress level as high, average, or low? *Circle one.*

Do you currently or have you previously used tobacco, e-cigarettes, or other types of vaping? ❑Yes ❑No

*Types used:*_____ *How much?*_____ *# Years* _____ *Interested in quitting?* ❑Yes ❑No

Do you now or have you in the past: Consumed Alcoholic Beverages? Y/N Recreational Drugs? Y/N

Yes / No	*List All Allergies*
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Jewelry or metals
☐ ☐	Latex
☐ ☐	Penicillin
☐ ☐	Sulfa

Other:_____

Yes / No	*Answer if Female*
☐ ☐	Do you take Birth Control?
☐ ☐	Are you pregnant? #wks_____
☐ ☐	Are you nursing?

Please list any prescription medications you take.

List or circle any health related substances you take routinely.
Include any vitamins, supplements, or natural products.

Gingko, Ginseng, Garlic, Ginger, Kava, St. John's Wort, Echinacea, Vit.E, Valerian

I certify that the above information is complete and accurate.

Patient/Guardian Signature_____ Date:_____

Dentist's Signature_____ Date:_____