Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain _____

Do you use tobacco? ☐ Yes ☐ No _____

Do you use controlled substances? ☐ Yes ☐ No _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Do you take, or have you taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates? ☐ Yes ☐ No _____

Do you take, or have you recently taken, any blood thinners? ☐ Yes ☐ No _____

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ Yes ☐ No If yes, please explain _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain _____

Are you taking any vitamins or supplements? ☐ Yes ☐ No If yes, please list _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes, please list _____

(additional room on back of form if needed) _____

Are you allergic or have you had any reactions to the following?

☐ Aspirin ☐ Penicillin/other antibiotics ☐ Codeine ☐ Acrylic ☐ Any metals (e.g.nickel, mercury, etc.) ☐ Latex ☐ Iodine ☐ Sedatives ☐ Local Anesthetics ☐ Sulfa Drugs ☐ Other_____

Do you have any allergies? Please list _____

WOMEN Are you: ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Please CHECK if you have, or have you had, any of the following:

☐ Abnormal bleeding with surgery	☐ Congestive Heart Failure	☐ Heart Pacemaker/Defibrillator	☐ Psychiatric Care
☐ ADD/ADHD	☐ Contact lenses	☐ Heart Trouble/Disease	☐ Radiation Treatments
☐ AIDS/HIV Positive	☐ Convulsions	☐ Hemophilia	☐ Recent Weight Loss
☐ Alzheimer's Disease	☐ COVID-19	☐ Hepatitis A	☐ Renal Dialysis
☐ Anemia	☐ Crohn's Disease	☐ Hepatitis B or C	☐ Rheumatic Fever
☐ Angina	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis/Gout	☐ Drug Addiction	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Easily Winded	☐ Hives or Rash	☐ Shingles
☐ Artificial Joint	☐ Eating Disorder	☐ Hypoglycemia	☐ Shortness of Breath
☐ Asthma	☐ Emphysema	☐ Hyperthyroidism/Hypothyroidism	☐ Sickle Cell Disease
☐ Bacterial Endocarditis	☐ Epilepsy or Seizures	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Excessive Thirst	☐ Kidney Problems	☐ Sleep disorder
☐ Blood Transfusion	☐ Fainting Spells/Dizziness	☐ Leukemia	☐ Spina Bifida
☐ Breathing Problem	☐ Frequent Cough	☐ Liver Disease	☐ Stomach/Intestinal Disease
☐ Bruise Easily	☐ Frequent Diarrhea	☐ Low Blood Pressure	☐ Stroke
☐ Cancer	☐ Frequent Headaches	☐ Lung Disease	☐ Swelling of Limbs
☐ Chemotherapy/Immunotherapy	☐ Genital Herpes	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Chest Pains	☐ Glaucoma	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Circulatory Problems	☐ Hay Fever	☐ Osteoporosis	☐ Ulcers
☐ Cold Sore/Fever Blisters	☐ Heart Attack	☐ Pain in Jaw Joints	☐ Venereal Disease
☐ Congenital Heart Disorder	☐ Heart Murmur	☐ Parathyroid Disease	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please explain:_____

Dental History

Reason for today's visit _____

Date of last dental visit _____ Date of last dental X-rays_____

Former Dentist (optional) _____

This form has been filled out accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Signature of Patient, Parent or Guardian Date

Doctor's Comments _____

_____ Signature_____ Date_____