Medical History

For Office Use Only
Med Consult : Yes *when_____ / No

Patient Name _____
Date of Birth _____ Age _____

Physician (PCP) Name _____
Address _____
Phone # _____ Fax # _____

☐ Yes ☐ No: ***REGULARLY TAKE ANTIBIOTICS PRIOR TO DENTAL TREATMENT?*** for _____
☐ Yes ☐ No: **Have you had Surgery for** ☐ **Any Pins** ☐ **Plates** ☐ **Artificial Joints?** When? (mmddyy) _____
☐ Yes ☐ No: **Have you had Heart Surgery?** ☐ **Stents** ☐ **Bypass** ☐ **Transplant** When? (mmddyy) _____

☐ **Have you been hospitalized for any reason?** Please describe:

_____

Do you take: ☐ **Bisphosphonates: Fosamax / Boniva / Actonel** ☐ **Blood Thinner: Warfarin / Coumadin / Plavix**
Please list your Medicines/Drugs:

_____

Are you allergic to: check applicable ☐ **Penicillin,** ☐ **Aspirin,** ☐ **Local anesthetics,** ☐ **Latex,** ☐ **Sulfa,** ☐ **Codeine**
Other? _____

Do you: Smoke? ☐ *Yes ☐ No **Chew Tobacco?** ☐ *Yes ☐ No *How many per day? _____ *How many years? _____

**** (For Female) *****
Are you pregnant? ☐ **Yes** ☐ **No @ Week:** _____ ☐ **1st** ☐ **2nd** ☐ **3rd Trimester / Due date:** _____
Are you nursing? ☐ **Yes** ☐ **No** **Do you take Birth Control Pills?** ☐ **Yes** ☐ **No**

Please check ALL conditions that apply to your health & for which you take medications:

☐ Blood Pressure: ☐ High or ☐ Low
☐ Heart Attack - When? (mm/yy) _____
☐ Heart murmur
☐ Mitral Valve Prolapse
☐ Rheumatic fever
☐ Irregular heartbeat or ☐ Heart murmur
☐ Pacemaker
☐ Stroke - When? (mm/yy) _____
☐ Epilepsy or ☐ Seizures (mm/yy) _____
☐ Infective Endocarditis (mm/yy) _____
☐ Diabetes: ☐ Type I or ☐ Type II
☐ Alzheimer's disease
☐ Thyroid disease: ☐ Hyper or ☐ Hypo
☐ Digestive problem: ☐ Ulcer ☐ Acid Reflux
☐ **Dry Mouth**
☐ **History:** ☐ **Lock Jaw** ☐ **TMJ Treatment**
☐ **Any other illnesses not checked above:**

☐ Asthma or ☐ Emphysema/COPD
☐ Depression or ☐ Anxiety
☐ Autism or ☐ ADD/ADHD
☐ Kidney problem _____
☐ Tuberculosis or ☐ Lung Disease
☐ Cancer - Type: _____
☐ Radiation ☐ Chemotherapy
☐ Liver problem: ☐ Jaundice ☐ Cirrhosis
☐ Hepatitis Type: _____
☐ Anemia or ☐ Blood Disorders _____
☐ Prolonged Bleeding: ☐ Cuts ☐ Extraction
☐ HIV or ☐ AIDS
☐ Hives ☐ Rash ☐ Herpes
☐ Trauma to: ☐ Face ☐ Neck ☐ Back
☐ Snoring or ☐ Sleep Apnea
☐ Drug or ☐ Alcohol Addiction

_____

DENTAL USE ONLY

BP: _____ / _____
Pulse: _____
Date: _____

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Pulse: _____
Date: _____

BP: _____ / _____
Pulse: _____
Date: _____

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information (Medical History) and Dental History are complete and accurate to the best of my knowledge.

Signature _____ **Date** _____
Patient / Parent / Legal Guardian

Dentist Signature _____ **Date** _____