

Name _____ Male/ Female Single Married Divorced Widowed
 Address _____ Last First Middle Birth Date _____ SS# _____
 City _____ State _____ Zip _____
 Home Ph. _____ Work Ph. _____ Cell Ph _____

Referring Dentist _____ How long with this Dentist _____

MEDICAL HISTORY

Emergency Contact _____ Phone # _____

Physician _____ Phone # _____

1. Are you under a physician's care now? Yes No Nature of treatment _____
 2. Have you ever been hospitalized and/or had surgery? Yes No Reason _____

3. Have you EVER had any of the following? Please check each box.

	YES	NO		YES	NO		YES	NO		YES	NO
High Blood Pressure			Mitral Valve Prolapse			Tuberculosis			Thyroid Problems		
Heart Attack			Heart Valve Replacement			Hepatitis			Organ Transplant		
Stroke			Artificial Joint			Jaundice			Diabetes		
Arrhythmias			Asthma			Liver Disorders			Epilepsy/Seizures		
Pacemaker			Seasonal Allergies			Kidney Disease			Severe Anxiety		
Rheumatic Fever			Sinus Problems			Arthritis			Blood Transfusion		
Heart Murmur			Respiratory Problems			AIDS/HIV Positive			Cancer		
Angina/Chest Pain			Ulcers			Drug Dependency			Syncope/Fainting		

4. Other medical concerns: _____

5. Are you currently taking any of the following? Please check each box.

	YES	NO		YES	NO		YES	NO
Antibiotics or Antibiotic Premedication			Aspirin			Thyroid Medications		
Medicine for High Blood Pressure			Anticoagulants (Blood Thinners)			Steroids		
Digitalis/Other Heart Medications			Tranquilizers (Valium)			Birth Control Pills		
Nitroglycerine			Sedatives			Pain Medications		
Antihistamines			Insulin/Diabetic Medications			Other Medications		

6. If you answered YES to any of the above, list name of the medication and dosage below: _____

7a. Are you sensitive or allergic to any of the following medications? Please check each box.

	YES	NO		YES	NO		YES	NO		YES	NO
Latex			Z-Pack			Epinephrine			Tylenol		
Penicillin/Amoxicillin			Erythromycin			Codeine			Ibuprofen		
Augmentin			Metronidazole/Flagyl			Hydrocodone			Aspirin		
Clindamycin			Topical Dental Anesthetics			Oxycodone			Steroids/Medrol Dose Pack		
Keflex			Lidocaine/Novocaine			Tramadol			Other: _____		

7b. What type of reaction did you have? _____

8. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?..... Yes No

9. Do you have any disease, condition or problem not mentioned above?..... Yes No

10. Female Patients: Are you pregnant? Yes No If Yes, what month? _____ Obstetrician _____

11. Have you ever taken bisphosphonate medications? (ex: Fosamax, Actonel, Boniva)..... Yes No

To the best of my knowledge, all the above answers are true and correct. I will inform my dentist of changes in my health and/or medications.

Patient's signature _____

Date _____

Reviewed _____

Patient's signature _____

Update _____

Reviewed _____

Patient's signature _____

Update _____

Reviewed _____