Medical History

First Name | Last Name | Birth Date | Date

Are you under the care of a physician?	☐ Yes ☐ No	If yes, explain below
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes, explain below
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes, explain below
Are you taking any medications,pills or drugs?	☐ Yes ☐ No	If yes, complete the medications section at the end
Do you take or have taken, Phen-Fen or Redux?	☐ Yes ☐ No	If yes, explain below
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes, explain below
Are you on a special diet?	☐ Yes ☐ No	If yes, explain below
Do you use tobacco?	☐ Yes ☐ No	If yes, explain below
Do you use controlled substances?	☐ Yes ☐ No	If yes, explain below
Has a physician or previous dentist recommended that you take antibiotics or pre-medication prior to your dental appointment?	☐ Yes ☐ No	If yes, explain below

Women: Are You..

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Iodine
☐ Ibuprofen	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetic

Do you have or have you had any of the following diseases or medical conditions?

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	Radiation Treatments
☐	☐	Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss
☐	☐	Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Renal Dialysis
☐	☐	Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Rheumatic Fever
☐	☐	Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Rheumatism
☐	☐	Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐	Scarlet Fever
☐	☐	Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Shingles
☐	☐	Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Disease
☐	☐	Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Sinus Trouble
☐	☐	Blood Disease	☐	☐	Frequent Cough	☐	☐	Joint Replacement	☐	☐	Spina Bifida
☐	☐	Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Kidney Problems	☐	☐	Stomach/Intestinal Disease
☐	☐	Bleeding Problems	☐	☐	Frequent Headaches	☐	☐	Leukemia	☐	☐	Stroke
☐	☐	Breathing Problem	☐	☐	Genital Herpes	☐	☐	Liver Disease	☐	☐	Swelling of Limbs
☐	☐	Bruise Easily	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease
☐	☐	Cancer	☐	☐	Hay Fever	☐	☐	Lung Disease	☐	☐	Tonsilitis
☐	☐	Chemotherapy	☐	☐	Heart Attack/Failure	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis
☐	☐	Chest Pains	☐	☐	Heart Murmur	☐	☐	Osteoporosis	☐	☐	Tumors or Growths
☐	☐	Cold Sores/Fever Blisters	☐	☐	Heart Pacemaker	☐	☐	Pain in Jaw Joints	☐	☐	Ulcers
☐	☐	Congenital Heart Disorder	☐	☐	Heart Trouble/Disease	☐	☐	Parathyroid Disease	☐	☐	Venereal Disease
☐	☐	Convulsions				☐	☐	Psychiatric Care	☐	☐	Yellow Jaundice

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

Unusual reaction to dental injection? ☐ Yes ☐ No

Are you in pain? ☐ Yes ☐ No

Do you have a Pano or Full Mouth x-rays less than 6 years old? ☐ Yes ☐ No

Do you have BiteWing x-rays less than 1 year old? ☐ Yes ☐ No

Name of former dentist | City/State | Date of last cleaning and exam

Comments

Medications

Please list any other medication(s) you are taking

Medication	Medication

Please list any allergies other than drug allergies:

Do you have any known allergies? ☐ Yes ☐ No

I certify that I have read and I understand the questions asked. I certify I have answered these questions in completion and do not hold the practice, doctor(s), or team responsible for any errors or omission that I have made in completing these forms.

I consent to the diagnostic procedures and treatment by the dentist(s) of this office necessary for proper dental care.

Signature of patient (Parent or Guardian if Minor)

Date