

**Medical History Form**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Phone Home \_\_\_\_\_  
Last First Middle Work \_\_\_\_\_  
Cell \_\_\_\_\_

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Yes No 1. Has there been any change in your general health within the past year?  
 2. My last physical examination was on \_\_\_\_\_
- Yes No 3. Are you now under the care of a physician? For What? \_\_\_\_\_  
 The name and address of my physician(s) is \_\_\_\_\_
- Yes No 4. Have you had any serious illness, operation, or been hospitalized in the past 5 years?  
 If so, what was the illness or problem? \_\_\_\_\_
- Yes No 5. Are you taking any medications? If so, what medications are you taking? \_\_\_\_\_  
 If you take Bisphosphonates (e.g. Fosamax or Boniva): \_\_\_\_\_oral form \_\_\_\_\_ IV form
- Yes No 6. Do you require premedication before dental treatment? For what condition? \_\_\_\_\_
- Yes No 7. Do you have, or have you had, any of the following?  
 Cardiovascular disease \_\_\_\_\_ Congenital heart defects \_\_\_\_\_ Heart attack \_\_\_\_\_ Angina \_\_\_\_\_  
 Coronary insufficiency \_\_\_\_\_ Coronary occlusion \_\_\_\_\_ Rheumatic Valvular damage \_\_\_\_\_  
 Mitral valve prolapse \_\_\_\_\_ High blood pressure \_\_\_\_\_ Arteriosclerosis \_\_\_\_\_ Stroke \_\_\_\_\_  
 Cardiac pacemaker \_\_\_\_\_ Heart Murmur \_\_\_\_\_ Artificial Heart Valve \_\_\_\_\_
- Yes No 8. Do you smoke cigarettes? How many per day \_\_\_\_\_
- Yes No 9. Do you have any contagious, sexually or otherwise transmissible disease?  
 Hepatitis, Jaundice, Liver disease \_\_\_\_\_ AIDS or HIV infection \_\_\_\_\_ Tuberculosis \_\_\_\_\_  
 Other \_\_\_\_\_ Comments \_\_\_\_\_
- Yes No 10. Are you allergic or react abnormally to any of the following:  
 Penicillin \_\_\_\_\_ Tetracycline \_\_\_\_\_ Erythromycin \_\_\_\_\_ Aspirin \_\_\_\_\_ Codeine \_\_\_\_\_  
 Local Anesthetics \_\_\_\_\_ Sulfa \_\_\_\_\_ Barbiturates \_\_\_\_\_ Latex \_\_\_\_\_ Other \_\_\_\_\_  
 Comments \_\_\_\_\_
- Yes No 11. Do you have, or have you had, any of the following?  
 Epilepsy, Seizures, Fainting Spells \_\_\_\_\_ Diabetes \_\_\_\_\_ Thyroid disease \_\_\_\_\_ Ulcers \_\_\_\_\_  
 Respiratory disease \_\_\_\_\_ Cancer \_\_\_\_\_ Kidney disease/Dialysis \_\_\_\_\_ Mental Health Disorder \_\_\_\_\_  
 Artificial Joints \_\_\_\_\_ Prolonged Bleeding \_\_\_\_\_ Radiation Treatments \_\_\_\_\_ Healing Complications \_\_\_\_\_  
 Persistent Cough (over three weeks) \_\_\_\_\_ Weight Loss \_\_\_\_\_ Anorexia \_\_\_\_\_ Bloody Sputum \_\_\_\_\_
- Yes No 12. Do you have any other conditions we should know about? If yes, what \_\_\_\_\_
- Yes No 13. Women: Are you:  
 Pregnant/Trying? Yes No Taking Oral Contraceptives? Yes No Nursing? Yes No  
 Due Date \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. 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. Parents of minors: If a responsible adult is not present at the time of treatment, we will provide standard and correct therapy, including the use of necessary x-rays.

\_\_\_\_\_  
Signature of patient, parent, or guardian

