Medical History

Patient Name: Birth Date: Date Created:

Primary physician name and contact information:	☐	If yes
Are you taking any medications (including supplements and vitamins)? If yes, please list:	○ Yes ○ No	If yes
Medication list provided on separate form?	○ Yes ○ No	
Are you taking blood thinners (e.g. Baby Aspirin, Coumadin, Xarelto)? If yes, please list:	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you take premedication (antibiotics prior to dental treatment)? If yes, why?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Have you ever used or are you currently using controlled substances?	○ Yes ○ No	If yes
Have you ever used or are currently using tobacco?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	If yes
Do you have sleep apnea?	○ Yes ○ No	If yes

Are you allergic to any of the following?

Aspirin	○ Yes ○ No	Penicillin	○ Yes ○ No	Codeine	○ Yes ○ No	Acrylic	○ Yes ○ No
Metal	○ Yes ○ No	Latex	○ Yes ○ No	Sulfa Drugs	○ Yes ○ No	Local Anesthetics	○ Yes ○ No
Milk	○ Yes ○ No	Gluten	○ Yes ○ No				

Other Allergies? ○ Yes ○ No If yes

Women: Are you...

Pregnant/Trying to get pregnant?	○ Yes ○ No	Nursing?	○ Yes ○ No	Taking oral contraceptives?	○ Yes ○ No

Do you have, or have you had any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug/Alcohol Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genitial Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Tattoos/Body Piercing	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve-Prolapse	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Ulcers	○ Yes ○ No
Venereal Disease	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No	Acid Reflux/Heartburn	○ Yes ○ No	Eating Disorder	○ Yes ○ No

Additional comments on any conditions listed above:	○ Yes ○ No	If yes
Have you ever had any serious illness not listed above?	○ Yes ○ No	If yes
Do you wish to talk to the dentist privately about any problem?	○ Yes ○ No	If yes

Signature of Patient, Parent or Guardian:

X Date:_____