MEDICAL HISTORY

Primary Physician's or Clinic Name _____ Phone (___)_____

Address of clinic or medical facility:_____

Are you currently under the care of a physician? ❑Yes ❑No Condition: _____

Have you been hospitalized in the last 5 years? ❑Yes ❑No Reason:_____

Please list all of the medications that you are taking in the box to the right →→→→→→

Have you ever taken medications/injection for Osteoporosis?
(Fosomax, Aredia, Boniva?) ❑Yes ❑No

Are you, or have you ever taken any "Blood Thinners" (Coumadin, Plavix?)

❑Yes ❑No

Allergies to Medications: Penicillin ❑Yes ❑No
Other Medications or Substances ❑Yes ❑No
*Please explain: _____
Anesthetic ❑Yes ❑No
Latex Products ❑Yes ❑No
Abnormal Blood Pressure? ❑Yes ❑No ❑High ❑Low

Do you currently or have you had to take antibiotics before dental treatment?
❑Yes ❑No ❑ **Premedication Required**

Do you currently smoke or use tobacco products? ❑Yes ❑No

Women: Are you pregnant? ❑Yes Due Date _____ ❑No Do you take any birth control medications? ❑Yes ❑No

List ALL Medications & Reason for taking include prescription, over-the-counter, vitamin & supplements.

(If you have a list we will copy it for your records)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have, or have you ever had any of the following:

Knee / Hip Replacement	❑Yes	❑No	Heart Valve Replacement	❑Yes	❑No
Anemia	❑Yes	❑No	Heart Murmur	❑Yes	❑No
Diabetes	❑Yes	❑No	Other Heart Condition	❑Yes	❑No
Cancer	❑Yes	❑No	HIV positive / AIDS	❑Yes	❑No
Epilepsy	❑Yes	❑No	Tuberculosis	❑Yes	❑No
Hepatitis	❑Yes	❑No	Lived with someone w/ Tuberculosis	❑Yes	❑No
Rheumatic Fever	❑Yes	❑No	Sinus Problems	❑Yes	❑No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify this doctor of my changes in my health or medication. Patient/Parent/Guardian: Signature _____ Date _____

Updated	Please list changes in health, medications, surgeries	initials	Updated	Please list changes in health, medications, surgeries	initials