Medical History

Name *

First Name

Last Name

Email Address *

Phone Number *

Are you currently being treated by a physician for a specific condition?

○ Yes ○ No

If so, please tell us about your treatment

Have you recently been hospitalized or had a major operation?

○ Yes ○ No

If so, please tell us about the hospitalization

Have you ever had a serious head or neck injury?

○ Yes ○ No

If so, please tell us about the head/neck injury

Are you taking any medications, pills, or drugs?

○ Yes ○ No

Please list all medications and dosage

Are you on a special diet?

○ Yes ○ No

Please tell us about your diet

Do you use tobacco?

○ Yes ○ No

Please tell us how often and what type of tobacco consumption

Recreational drug and/or alcohol use, combined with local anesthesia may cause a life-threatening emergency.

Have you ever been advised that you require antibiotics prior to a dental appointment?

○ Yes ○ No

Please tell us about the antibiotics

Do you take, or have you taken, PhenFen or Redux?

○ Yes ○ No

If so, please tell us about your PhenFen/Redux usage

Have you ever taken Fosomax, Boniva, Actonel or any other medications containing bisphosphonates?

○ Yes ○ No

If so, please tell us about your bisphosphonate usage

Have you recently used controlled substances?

○ Yes ○ No

If so, please tell us which controlled substances and amount/frequency

Have you recently consumed alcohol?

○ Yes ○ No

Please tell how much alcohol and how recently

Please answer if filling this form out on the day of your appointment

Women (Please check all that apply)

Have you ever had an adverse reaction or allergies to any medication or substance? (Please check if allergic) *

- [ ] Aspirin
- [ ] Acrylic
- [ ] Erythromycin
- [ ] Iodine
- [ ] Latex
- [ ] Local Anesthetics
- [ ] Metal
- [ ] Novocaine
- [ ] Nitrous Oxide
- [ ] Penicillin
- [ ] Sulfa Drugs
- [ ] Tetracycline
- [ ] Valium
- [ ] Xylocaine
- [ ] None of the Above
- [ ] Other

If other, please list

Do you have, or have you ever had any of the following medical conditions? (Please select all that apply) *

- [ ] Anemia
- [ ] Chemotherapy
- [ ] Cold Sores/Fever Blisters
- [ ] Cortisone Medication
- [ ] Excessive Bleeding
- [ ] Frequent Cough
- [ ] Frequent Headaches
- [ ] Hay Fever
- [ ] Hemophilia
- [ ] High Blood Pressure
- [ ] Hives or Rash
- [ ] Kidney Problems
- [ ] Liver Disease
- [ ] Parathyroid Disease
- [ ] Recent Weight Loss
- [ ] Rheumatism
- [ ] Shingles
- [ ] Spina Bifida
- [ ] Stroke
- [ ] Thyroid Disease
- [ ] Venereal Disease
- [ ] Arthritis or Gout
- [ ] Blood Disease
- [ ] Bruise Easily
- [ ] Congenital Heart Problems
- [ ] Diabetes
- [ ] Drug/Alcohol Addiction
- [ ] Emphysema
- [ ] Frequent Urination
- [ ] Heart Murmur
- [ ] Heart Valve or Pacemaker
- [ ] Herpes
- [ ] Hypoglycemia
- [ ] Lung Disease
- [ ] Rheumatic Fever
- [ ] Tuberculosis
- [ ] Ulcers or GI Problems
- [ ] Asthma
- [ ] Chest Pains
- [ ] Convulsions
- [ ] Easily Winded
- [ ] Excessive Thirst
- [ ] Frequent Diarrhea
- [ ] Genital Herpes
- [ ] Heart Attack/Heart Failure
- [ ] Hepatitis (B or C)
- [ ] Low Blood Pressure
- [ ] Irregular Heartbeat
- [ ] Leukemia
- [ ] Mitral Valve Prolapse
- [ ] Radiation Treatments
- [ ] Renal Disease
- [ ] Scarlet Fever
- [ ] Sickle Cell Disease
- [ ] Stomach/Intestinal Disease
- [ ] Swelling of Limbs
- [ ] Tonsillitis
- [ ] Yellow Jaundice
- [ ] Artificial Joint
- [ ] Blood Transfusion
- [ ] Cancer
- [ ] Currently Pregnant
- [ ] Dizziness or Fainting
- [ ] Eating Disorder
- [ ] Epilepsy or Seizures
- [ ] Glaucoma
- [ ] Heart Trouble
- [ ] Hepatitis (A)
- [ ] HIV-AIDS-ARC
- [ ] Jaw Joint Pain
- [ ] Psychiatric Care
- [ ] Sinus Problems
- [ ] Tumor or Growth
- [ ] X-ray/Chemotherapy
- [ ] No to All

Do you have any condition or problem, not listed, which we should know about? Please explain

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.

Signature *