Medical History

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Patient First Name: _____ Patient Last Name: _____

Date of Birth: _____ Phone: _____ Today's Date: _____

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____ Relationship: _____

MEDICAL HISTORY

Physician's Name: _____

Address: _____

Are you now under the care of a physician? ○ Yes ○ No

If yes, for what reason? _____

Are you presently taking any medications/drugs/pills? ○ Yes ○ No

Have you or anyone in your family had an adverse reaction to local anestheisa, IV sedation, or general anesthesia? ○ Yes ○ No

Is there anything you would like to discuss privately with the Dentist? ○ Yes ○ No

MEDICATIONS

List prescriptions (including birth control pills), vitamins, herbal supplements, natural products, over-the-counter drugs taken routinely and controlled substances. Include dosages if available.

ALLERGIES / SENSITIVITIES

Are you allergic / sensitive (or ever had an adverse reaction) to: *Check all that apply or check none*

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Metals ☐ LATEX ☐ **NONE**

☐ Aspirin ☐ Other Antibiotics ☐ Other Medications or Substances: _____

Describe reaction: _____

BISPHOSPHONATES

Have you ever or are you currently taking or scheduled to begin taking any of the medications, alendronate (Fosamax®), risedronate (Actonel®) or ibrandronate (Boniva®) for osteoporosis or Paget's disease?

○ Yes ○ No

Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

○ Yes ○ No Date treatment began: _____

-- For questions requiring longer responses, please use "Comments" section on page 3 of this form. --

Have you ever used or currently use tobacco products? ○ Yes ○ No How long ago did you quit? _____

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew How much? _____ How often? _____

Do you use marijuana? ○ Yes ○ No How much? _____ How often? _____

Do you drink alcoholic beverages? ○ Yes ○ No How much? _____ How often? _____

Do you vape or use e-cigarettes? ○ Yes ○ No

WOMEN: Are you pregnant or suspect that you may be? ○ Yes ○ No **Are you nursing?** ○ Yes ○ No

Do you have, or have you ever had any of the following: (YES OR NO)

	YES	NO		YES	NO
1. Artificial (prosthetic heart valve)	○	○	32. Blood Disorders	○	○
2. Previous infective endocarditis	○	○	33. Anemia	○	○
3. Damaged valves in transplanted heart	○	○	34. Leukemia	○	○
4. Congenital heart disease (CHD)			35. Prolonged Bleeding	○	○
Unrepaired, cyanotic CHD	○	○	36. Hemophilia	○	○
Repaired (completely) in last 6 months	○	○	37. Sickle Cell Disease	○	○
Repaired CHD with residual defects	○	○	38. Cancer	○	○
5. Heart Disease/Surgery	○	○	39. Tumors	○	○
6. Heart murmur	○	○	40. Chemotherapy	○	○
7. Heart pacemaker	○	○	41. Radiation Therapy	○	○
8. Rheumatic fever/heart disease	○	○	42. Neurological Disorders	○	○
9. Mitral valve prolapse	○	○	43. Epilepsy	○	○
10. High/low blood pressure	○	○	44. Stroke	○	○
11. Learning Disability	○	○	45. Arthritis / Rheumatism	○	○
12. Mental Health Disorder	○	○	46. Autoimmune Disease	○	○
13. Anorexia	○	○	47. Artificial Joint / Prosthesis	○	○
14. Bulimia	○	○	48. Liver Disease	○	○
15. Lung disease/COPD	○	○	49. Hepatitis (select one)	○	○
16. Tuberculosis	○	○	Type: ○A ○B ○C ○Other ○None		
17. Asthma	○	○	50. Ulcers	○	○
18. Shortness of Breath	○	○	51. Gastrointestinal Disease	○	○
19. Respiratory Ailments	○	○	52. GERD (gastric reflux)	○	○
20. Emphysema	○	○	53. Deaf or Hard of Hearing	○	○
21. Sinus Trouble	○	○	54. Glaucoma	○	○
22. Diabetes Type I or Type II	○	○	55. Cortisone Medication	○	○
23. Thyroid Problems	○	○	56. Fainting Spells	○	○
24. Persistent swollen glands	○	○	57. Organ Transplant	○	○
25. Kidney Problems	○	○	58. Removal of Spleen	○	○
26. Venereal Disease	○	○	59. Osteoporosis	○	○
27. HIV Positive/AIDS/ARC	○	○	60. Sleep Disorder	○	○
28. Alcohol Addiction	○	○	61. Elevated Cholesterol	○	○
29. Drug Dependency	○	○	62. Anxiety	○	○
30. Chemical Dependency	○	○	63. Depression	○	○
31. Dementia	○	○	64. Alzheimer's	○	○

Have you had any other serious illness, hospitalization or accident? ○ Yes ○ No

If yes, please explain: _____

-- For questions requiring longer responses, please use "Comments" section on page 3 of this form. --

COVID-19

Have you had COVID-19? No ◯ Yes ◯ Date _____

Received COVID-19 vaccine? No ◯ Yes ◯ Date _____

Emergency Contact

Name: _____ Phone: _____

COMMENTS

I understand the information entered on this form 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 the doctor of any changes in my health or medication.

When completing a printed form, please sign below

Patient _____ Date _____

Patient or Patient Guardian

Doctor _____ Date _____

Doctor or Provider of Care