MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Occupation: _____

Cell Phone: _____ Referred by: _____

Physician: _____ Phone Number: _____

Specialist: _____ Phone Number: _____

Please circle YES or NO to answer the following questions:

YES / NO 1. Are you in good general health?

YES / NO 2. Have you been hospitalized or had a serious illness?

If so, when and for what? _____

_____

YES / NO 3. Have you had any **joint replacement**?

YES / NO 4. Are you taking any **blood thinner medications**?

YES / NO 5. Are you pregnant?

YES / NO 6. Do you **smoke, vape or use tobacco** products?

YES / NO 7. Are you taking **OSTEOPOROSIS** medications (Fosamax, Boniva, etc.)?

YES / NO 8. Have you been told to take antibiotics (Premedicate for a dental visit?)

YES / NO 9. Are your teeth sensitive?

YES / NO 10. Do you have sores/blisters in your mouth?

YES / NO 11. Have you been diagnosed with Periodontal disease?

YES / NO 12 Please check any items below you use in your mouth:

- ☐ Sleep apnea machine
- ☐ Retainer
- ☐ Occlusal guard/night guard
- ☐ Sports guard

Do you have allergies to the following listed below:

- ☐ Local anesthesia (Novocain)
- ☐ Codeine
- ☐ Latex
- ☐ Seasonal allergies
- ☐ Aspirin
- ☐ Sulfa Drugs
- ☐ other drugs or medications
- ☐ Antibiotics (Penicillin, Amoxicillin, Clindamycin)

Any allergies not listed above: _____

Please list any medications you are taking _____

_____

Emergency contact info:

Relation: _____

Name: _____ Phone #: _____

Do you have or had any of the following:

- ☐ Heart disease
- ☐ Congenital heart defects
- ☐ Heart attack
- ☐ Angina
- ☐ Congestive heart failure
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Pacemaker
- ☐ Artificial heart valve
- ☐ High/low blood pressure
- ☐ Diabetes TYPE ____
- ☐ Fainting spells
- ☐ Bleeding disorders
- ☐ Arthritis
- ☐ Chemotherapy
- ☐ Cancer
- ☐ Radiation Therapy
- ☐ Migraines/severe headaches
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Auto Immune Disease
- ☐ AIDS/HIV
- ☐ Herpes
- ☐ Joint replacement
- ☐ Stomach ulcers
- ☐ GI Disease or GERD
- ☐ Epilepsy

Signature: I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I will not hold my dentist or any member of his/her dental team responsible for errors or omissions that I have made upon completion of this form. It is my responsibility to notify my dentist or any changes in the above medical status.

Patient or Responsible Party SIgnature _____ **Date** _____

Date	Signature	Changes to Medical History