

Please be aware that disclosure of your health history (including medications you may take) is important for us to know so that we may provide you with the best care. Thank you.

Patient Name: _____ Birth Date: _____/_____/_____

Are you under a physician's care now? Please name Dr. and location Yes No

If yes: _____

Have you recently (in the few last years) been hospitalized or had major surgery? Yes No

If yes: _____

Are you currently taking blood thinners (Warfarin, Coumadin, Xarelto, Eliquis or other)? Yes No

If yes: _____

Have you ever taken bisphosphonates for osteoporosis, (Fosamax, Prolia, Boniva, Actonel)? Yes No

If yes: _____

Are you taking any other medications, vitamins or herbal supplements? Please list Yes No

If yes: _____

Have you ever been told to take an antibiotic prior to dental treatment? Reason why Yes No

If yes: _____

Do you regularly consume 2 or more alcoholic beverages per day? Yes No

If yes: _____

Do you use tobacco (in any form)? Please specify Yes No

If yes: _____

Do you use controlled substances? Yes No

If yes: _____

Have you ever been diagnosed with sleep apnea? Yes No

If yes, do you currently use a CPAP machine or sleep appliance? Specify: _____

Would you like to speak to the Doctor privately about any other health concerns? Yes No

If yes: _____

Women: Are you

Pregnant?

Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin

Penicillin/Amoxicillin

Codeine

Acrylic

Metal

Latex

Sulfa Drugs

Local Anesthetics

Do you have any other allergies? Please specify _____

Please continue Medical History form on back →

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

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Heart Disease/Mitro Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A, B or C	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No
Blood Pressure - High	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No
Blood Pressure - Low	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No
Botox Injection	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Shunt/Stent	<input type="radio"/> Yes <input type="radio"/> No
Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Teeth Grinding/Clenching	<input type="radio"/> Yes <input type="radio"/> No
Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Headaches Frequently	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No

If yes: _____

Comments:

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 of Patient, Parent or Guardian:

X _____ Date: _____