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Medical History

Patients Name:______________________________ Date of Birth:___________________________

Date of Last Physical:__________________Physicians Name & Phone:___________________________

Date of Last Dental Visit:__________________ Date of Last Dental Cleaning_______________________

Have you ever been hospitalized? ☐Yes ☐No Reason for today's Visit?______________________________

Have you ever taken antibiotics prior to dental procedures? ☐Yes ☐No

Are you currently taking or have taken Oral or IV Bisphosphonates (e.g., FOSMAX, ACTONEL, BONIVA, ZOMETA, AREDIA)? ☐Yes ☐No If Yes, how long have you taken them?__________________________

Have you or a family member every been treated for periodontal disease ☐ Yes ☐No

Do you wear dentures if so, how old are they? ________________ Are you interested in new dentures? ☐Yes ☐ No

Have you ever had complications from an extraction? ☐ Yes ☐ No

Have you ever had Novacaine or local anesthetic? ☐Yes ☐ No

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? ☐ Yes ☐No

List any medications you are allergic to:

1. __________________2.__________________ 3.__________________ 4.__________________

List any medications you are taking including non-prescription drugs and herbals/vitamins:

1.__________________2.__________________3.__________________4.__________________

Do you have a history of :	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth sores/growths		
Diabetes			Teeth grinding/clenching			Pace Maker/Heart Surgery			Aspirin/Anticoagulant Therapy		
Venereal Disease			Arthritis			Pain in your Jaw (TMJ)			Ulcers or Stomach Problems		
High Blood Pressure			HIV Positive/AIDS			Latex Allery			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Cancer (type:_________)		
Any type of Transplant			Heart Problems			Excessive Bleeding			Any Artificial Joint		
Drug Addiction			Dialysis			Stroke			Tumor or Growths		
Hepatitis (Type: ______)			Chemotherapy			Lung Disease			Chron's Disease		
Liver Disease			Radiation Treatment			Breathing Problems			ADHD/ ADD		
Kidney Disease			Use of Tobacco Products			Tuberculosis (TB)			Heart Surgery		
Frequent Headaches			Orthodontic Treatment			Sensitive Teeth			Snoring		
Other Disease or Illness:											

Woman Patients Only:	Y	N		Y	N
Is there the possibility of pregnancy?			Are you currently nursing?		
Estimated Delivery Date:			Are you taking any birth control Prescriptions?		

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I herby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient Signature:______________________________Date:______________________________

Doctor Signature:______________________________Date:______________________________