Medical History

Medical Doctor | Telephone:

Address:

City, State, Zip:

Do you presently have or have you had…		Yes	No	Official Use Only
1.	Are you under the care of a physician? Why?________________________________	O	O	
2.	Are you currently taking any medications including herbal therapies?........................ **(Please list on the back side of this form)**	O	O	
3.	Do you have any allergies? (i.e. to medications, latex, metals, etc.)........................... **List**:____	O	O	
4.	Have you ever had excessive bleeding requiring special treatment?............................	O	O	
5.	Congenital Heart Disease?..	O	O	
6.	High blood pressure?..	O	O	
7.	Heart disease or heart attack?..	O	O	
8.	Stroke?...	O	O	
9.	Angina pectoris (chest pain)?..	O	O	
10.	Heart murmur? (type)_________________________________..................................	O	O	
11.	High Cholesterol……………………………………………………………........................	O	O	
12.	Rheumatic Fever?...	O	O	
13.	Scarlet Fever?..	O	O	
14.	Artificial heart valve or artificial joints?...	O	O	
15.	Fast, irregular heartbeat?...	O	O	
16.	Pacemaker?..	O	O	
17.	Tuberculosis (TB)?...	O	O	
18.	AIDS or HIV antibody?..	O	O	
19.	Immune Deficiency?...	O	O	
20.	Hemophilia, anemia, leukemia, or other blood disease?..	O	O	
21.	Do you or have you ever taken Bisphosphonates?...	O	O	
22.	Breathing difficulties- (asthma, emphysema, hay fever, or sinus problems)?................	O	O	
23.	Diabetes? ☐ Type I ☐ Type II..	O	O	
24.	Thyroid disease (low or high hormone levels)?..	O	O	
25.	Stomach problems, ulcers, irritable bowel, or acid reflux (GERD)................................	O	O	
26.	Liver disease, hepatitis or yellow jaundice?...	O	O	
27.	Arthritis or rheumatism?..	O	O	
28.	Mental illness, depression, epilepsy (seizure), fainting or dizzy spells?.........................	O	O	
29.	Kidney disease or dialysis?..	O	O	
30.	Glaucoma?..	O	O	
31.	Venereal Disease (Syphilis, Gonorrhea, Herpes, etc.)?..	O	O	
32.	Cancer or other tumors?..	O	O	
33.	Cancer treatment, such as radiation or chemotherapy?..	O	O	
34.	Do you smoke or use smokeless tobacco?..	O	O	
35.	Do you have any disease, condition or problem not listed?... List:____	O	O	
Women:				
36.	Are you pregnant now?..	O	O	
37.	Are you currently using a prescription-type contraceptive?..	O	O	

Consent:
To the best of my knowledge, all of the preceding health history answers are true and correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment. I also hereby authorize the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapies that may be indicated, and further authorize and consent that the doctor choose and employ such assistance as he deems fit. I also understand that the use of anesthetic agents embodies risk and may be used during treatment procedures.

Patient ____ **Date** ______________________
(print patient's name)

Signature ____________________________________ **Relation to Patient**_________________________
(patient or guardian)

Reviewing Dr. ____ Date ______________________

Patient Name

Medications and Herbal Use

	Medication(s)	*Dose/Frequency*	*Reason for taking*
1			
2			
3			
4			
5			
6			

Medical History and Medical Update

Date	Change in Medical History and Medications	Patient's Signature	Doctor's Signature