

# Medical History

Patient Name \_\_\_\_\_

**WELCOME,** Please take the time to complete this form with your current medical information. You, and your families medical history will influence your susceptibility to certain dental conditions. The following information should be as complete and accurate as possible as we use it to select the most appropriate dental care for you. Please inform us of any changes to your medical history in the future.

Physician's Name \_\_\_\_\_ Physician's Address \_\_\_\_\_

Date of your last medical physical: \_\_\_\_\_ Are you currently under the care of a physician? Y / N  
Why? \_\_\_\_\_

Please check any of the following conditions that you have or have had in the past:

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal Bleeding                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis, Type:                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia/Blood disorders                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes/Cold Sores/Shingles         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Any heart problems                         | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney/Liver Problems              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis/Rheumatism                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Mental/Emotional Disorders         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Heart Valve Implant             | <input type="checkbox"/> Yes <input type="checkbox"/> No Nervous Problems                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma/Hay fever                           | <input type="checkbox"/> Yes <input type="checkbox"/> No Organ Transplant, Type:            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Pressure Problems: High / Low        | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis or Osteopenia         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer, Type:                              | <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthetic Joint Replacement Date: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Breathing, Emphysema, COPD      | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation or Chemotherapy Why:     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Drug Addiction                             | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy or Seizures                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems                     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting or Dizzy Spells                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Problems                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Headaches, shoulder or neck aches | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke                             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma or light sensitivity              | <input type="checkbox"/> Yes <input type="checkbox"/> No Tested Positive for HIV            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur                               | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid: Hypothyroid/Hyperthyroid  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes: Type 1 or Type 2                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis                       |

Date Diagnosed \_\_\_\_\_ Controlled or Uncontrolled? By Medication or Diet?

Have you ever taken Bisphosphonates such as Actonel, Boniva, Didronel, or Fosamax? Y / N If yes, what: \_\_\_\_\_

Have you ever taken any prescription weight loss products? Y / N If yes, what: \_\_\_\_\_

Have you ever had a serious illness or major surgery not listed above? Y / N If yes, please explain: \_\_\_\_\_

Is there a family history of Diabetes, Heart Disease, Oral Cancer, or Periodontal Disease? Y / N If yes, please explain: \_\_\_\_\_

Would you describe your stress level as high, average, or low? Circle one.

Do you smoke, chew, use snuff, or any other forms of tobacco? Y / N Circle those that apply.

How long have you used tobacco? \_\_\_\_\_ How much do you use? \_\_\_\_\_

Have you ever quit or thought about quitting? \_\_\_\_\_ Are you interested in quitting? \_\_\_\_\_

**Please list any medications you are currently taking,**  
Include prescription and non-prescription:

**List any health related substances you take routinely.**  
Include any vitamins, supplements, or natural products.

**Yes / No List All Allergies**

- |                          |                          |                    |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Latex              |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin         |
| <input type="checkbox"/> | <input type="checkbox"/> | Sulfa              |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin            |
| <input type="checkbox"/> | <input type="checkbox"/> | Codiene            |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Jewelry or metals  |

Other: \_\_\_\_\_

**If female, please answer the following:**

Are you taking Birth Control Pills? Y / N

Are you pregnant? Y / N If Yes, # of weeks \_\_\_\_\_

Are you nursing? Y / N

I certify that the above information is complete and accurate.

Patient/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Dentist's Initials \_\_\_\_\_ Date: \_\_\_\_\_