Medical History and Information

Patient Name________________________________ Date of Birth________________________

Primary Medical Doctor__________________________ Date and Reason of last visit____________________________________

Please circle Yes (Y) or No (N) along with the date if you have or have ever had any of the following:

Y	N	Abnormal Bleeding	Y	N	Congestive Heart Failure	Y	N	Heart Attack	Y	N	Psychiatric Treatment
Y	N	Acid Reflux	Y	N	Convulsions	Y	N	Heart Disease	Y	N	Radiation Therapy
Y	N	Alcohol Use/Abuse	Y	N	Cortisone Medicine	Y	N	Heart Surgery	Y	N	Rheumatic Fever
Y	N	Alzheimer's Disease	Y	N	Diabetes I or II	Y	N	Heart Murmur	Y	N	Rheumatism
Y	N	Anaphylaxis	Y	N	Difficulty Breathing	Y	N	Hemophilia	Y	N	Seasonal Allergies
Y	N	Anemia	Y	N	Drug Use/Abuse	Y	N	Hepatitis A, B, or C	Y	N	Seizures
Y	N	Angina Pectoris	Y	N	Eating Disorder	Y	N	High Blood Pressure	Y	N	Sexually Transmitted Disease
Y	N	Arthritis	Y	N	Endocarditis	Y	N	HIV/AIDS	Y	N	Sickle Cell Disease
Y	N	Artificial Heart Valve	Y	N	Emphysema	Y	N	Hives/Rash	Y	N	Sinus Problems
Y	N	Blood Transfusion	Y	N	Epilepsy	Y	N	Joint Replacement	Y	N	Steroid Treatment
Y	N	Bruise Easily	Y	N	Facial Surgery	Y	N	Kidney Problems	Y	N	Stroke
Y	N	Cancer	Y	N	Fainting Spells	Y	N	Liver Disease	Y	N	Thyroid Disease
Y	N	Chemotherapy	Y	N	Frequent Headaches	Y	N	Low Blood Pressure	Y	N	Tobacco Use
Y	N	Chest Pain	Y	N	Glaucoma	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis
Y	N	Cold Sores/Fever Blisters	Y	N	Genital Herpes	Y	N	Pace Maker	Y	N	Ulcers
Y	N	Congenital Heart Defect	Y	N	Hay Fever	Y	N	Pain in Jaw Joints	Y	N	Unexplained Weight Loss

Any current or history of other condition not listed above:____

Please list all current medications and dosages:

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Are you currently taking in blood thinning medications? (ie. Coumadin, Warfarin, Plavix, Aspirin…)____________________________

Are you currently or have you ever taken any bisphosphonates for osteoporosis? (ie Actonel, Boniva, Fosamax, Didronal, Risedronate, IV therapy…) If yes, please list name, dose, and date taken: ____

Are you allergic to any of the following? If yes, please check and explain reaction:

☐ Aspirin ☐ **Latex** ☐ Iodine ☐ Metals ☐ Sulfa Drugs ☐ Benzodiazepines

☐ **Penicillin** ☐ Cephalosporins ☐ Local Anesthetics ☐ Dyes ☐ **Amoxicillin**

Other Known Allergies (including to any to other medications):

____

Have you been hospitalized or had any major surgeries, please explain:

____

Female Patients: Are you pregnant?______________________If yes, what is your due date?_______________________

Are you nursing?_______________________Are you taking birth control pills?____________________

I have answered the above health history questions truthfully and to the best of my knowledge. I understand this information is important in order to receive dental care in the safest possible manner.

Signature____Date____________________________

Comments:____

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Doctor's Signature____Date___________________________