

MEDICAL HEALTH HISTORY

Please complete both sides of page

Patient Name: _____ Date: _____

Physician's Name _____

Physician's Phone Number: _____

Your current health is? (Circle) Good Fair Poor

Are you currently under the care of a physician for a health condition? Yes No

If yes, for what condition: _____

Please list all prescriptions you are currently taking:

Are you allergic to or had a bad reaction to any of the following: (Circle Y or N)?

- | | | | | | |
|---|---|--------------|---|---|--------------------|
| Y | N | Penicillin | Y | N | Tetracycline |
| Y | N | Erythromycin | Y | N | Sulfa |
| Y | N | Aspirin | Y | N | Latex |
| Y | N | Metals | Y | N | Dental Anesthetics |

Have you had a bad reaction to any other medicine or materials? Y N If yes, please list: _____

Please list all over-the-counter medications or "supplements" you are taking:

Have you had an artificial bones or joint replacement? Y _____ N _____ Date of Procedure _____

Have you experienced any of the following diseases or medical problems? (Circle Yes or No)

- | | | |
|-----------------------------|----------------------------------|----------------------------------|
| Y N High Blood Pressure | Y N Epilepsy or seizures | Y N Cancer or Tumors |
| Y N Abnormal Bleeding | Y N Emphysema | Y N Kidney problems |
| Y N Stroke | Y N Tuberculosis | Y N Venereal disease or STD's |
| Y N Heart attack | Y N Persistent cough | Y N HIV+/ AIDS |
| Y N Heart Surgery | Y N Diabetes | Y N Chemo or radiation treatment |
| Y N Low Blood Pressure | Y N Fainting spells | Y N Drug or alcohol abuse |
| Y N Heart Valve replacement | Y N Frequent or severe headaches | Y N Herpes or Cold sores |
| Y N Heart murmur | Y N Hepatitis or liver disease | Y N Steroid Therapy |
| Y N Pacemaker | Y N Glaucoma | Y N Thyroid issues |
| Y N Asthma | Y N Arthritis | Y N Psychiatric episodes |
| Y N Anemia | Y N Colitis or Ulcers | |

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Are you now taking, or have you ever taken any medications to strengthen your bones or increase your bone density? Please circle: Y N

If yes, what medication? _____

Have you ever been told that you should take antibiotics prior to dental work or dental cleanings? Y N

Do you smoke or use tobacco in any form? Y N

Please list any serious medical condition(s) that you have experienced: _____

Women Only:

Are you pregnant? Y N Unsure If yes, how far along are you (months)? _____

Are you nursing? Y N Are you taking birth control medication? Y N

Dental History

Why have you come in today? _____

How would you describe your current dental health? _____

Are you happy with your smile, and if not, what would you change? _____

Previous dentist's name and approximate date of last visit: _____

I affirm that the information I have given on this form is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical/health status.

Signature: _____ Date: _____

Office Notes: _____
