MEDICAL/HEALTH HISTORY

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name_____ Birth date ____/____/_____ cell phone_____

Preferred Pharmacy _____

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Alcoholism
- ❑ Allergies or hives
- ❑ Anemia or blood disorders
- ❑ Arthritis
- ❑ Artificial joint or valve
- ❑ Asthma
- ❑ Blood transfusion
- ❑ Cancer or tumor
- ❑ Diabetes
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Glaucoma
- ❑ Hayfever
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Hepatitis or other liver disease
- ❑ Herpes or cold sores
- ❑ High or low blood pressure
- ❑ HIV positive or AIDS
- ❑ Kidney disease
- ❑ Mental disorders
- ❑ Migraine headaches or frequent headaches
- ❑ Nervous disorders/Neurologic condition
- ❑ Pacemaker
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Sinus problems
- ❑ Stomach problems
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal disease

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Do you need to pre-medicate with antibiotics prior to any dental appointment: ❑ yes ❑ no

Women only: May be pregnant Y N
Expected delivery date _____
Are you nursing Y N

Are you allergic to or have you reacted adversely to any medications? (For example antibiotics, narcotics, local anesthetics or other materials i. e. LATEX used in a dental/medical office.) **If yes, please list them below:**

_____
_____
_____
_____
_____
_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antidepressants or tranquilizers
- ❑ Bisphosphonates (for osteoporosis or cancer)
- ❑ Cortisone or other steroids
- ❑ Fish Oil
- ❑ High blood pressure medicine
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin

Current medications:

_____
_____
_____
_____
_____
_____
_____

Today's blood pressure:_____

Date of last physical exam:_____

Updates:_____
_____
_____
_____

Date of last dental visit:_____Reason for this visit:_____

Have you ever had any complications following dental treatment? ❑ yes ❑ no _____

Name of your physician:_____phone:_____

Do you have any disease, condition, or problem not listed above?_____

EMERGENCY CONTACT (Name & Phone Number): _____

Signature of patient (or parent) _____ Date _____