

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: _____

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

Name of your physician: _____ phone: _____

EMERGENCY CONTACT (Name & Phone Number): _____

Signature of patient (or parent) _____ Date _____
