Patient Medical History

Patient's Name: ____ Birthdate: ________________

Health Problems that you may have, medication that you may be taking, could have an important interaction with the dentistry that you will be receiving. Thank you for answering these questions.

Are you in good health? Yes ___ No___ Are you under a doctor's care? Yes ___ No ___

Have you been hospitalized for any reason? (list) ____

Are you taking any medications? (list) ____

Are you taking any anticoagulants? Yes___ No___ Have you taken any bisphosphonantes? Yes___ No___

Women Only: Pregnant Yes ____ No ____ Nursing Yes ____ No ____ Taking Birth Control Yes ____ No ____

Are you allergic to or have you had a reaction to any of the following?

Local Anesthetic	Yes ___ No ___	Penicillin	Yes ___ No___	Aspirin	Yes ___ No ___
Codeine	Yes ___ No ___	Latex	Yes ___ No ___	Sulfa Drugs	Yes ___ No___
Metal	Yes ___ No ___	Other ______________________			

Do you have or have you had any of the following:

AIDS/HIV Positive	Yes ___ No ___	Alzeimer's Disease	Yes ___ No___	Anaphlaxis	Yes ___ No ___
Anemia	Yes ___ No ___	Angina	Yes ___ No ___	Arthritis/Gout	Yes ___ No ___
Artificial Heart Valve	Yes ___ No ___	Artificial Joint	Yes ___ No ___	Asthma	Yes ___ No ___
Blood Disease	Yes ___ No ___	Blood Transfusion	Yes ___ No ___	Bruise Easily	Yes ___ No ___
Breathing Problems	Yes ___ No ___	Cancer	Yes ___ No ___	Chemotherapy	Yes ___ No ___
Chest Pains	Yes ___ No ___	Cold Sores/Fever Blister	Yes ___ No ___	Convulstions	Yes ___ No ___
Congenital Heart Disorder	Yes ___ No ___	Cortisone Medicine	Yes ___ No ___	Diabetes	Yes ___ No ___
Drug Addiction	Yes ___ No ___	Easily Winded	Yes ___ No ___	Emphysema	Yes ___ No ___
Epilepsy/Siezures	Yes ___ No ___	Excessive Bleeding	Yes ___ No ___	Excessive Thirst	Yes ___ No ___
Faint/Dizzy Spells	Yes ___ No ___	Frequent Cough	Yes ___ No ___	Frequent Diarrhea	Yes ___ No ___
Frequent Headaches	Yes ___ No ___	Genital Herpes	Yes ___ No ___	Glaucoma	Yes ___ No ___
Hay Fever	Yes ___ No ___	Heart Attack/Failre	Yes ___ No ___	Heart Disease	Yes ___ No ___
Hemophilia	Yes ___ No ___	Hepatitis A	Yes ___ No ___	Hepatitis B or C	Yes ___ No ___
Herpes	Yes ___ No ___	High Blood Pressure	Yes ___ No ___	High Cholesterol	Yes ___ No ___
Hives or Rash	Yes ___ No ___	Hypoglycemia	Yes ___ No ___	Irregular Heartbeat	Yes ___ No ___
Kidney Problems	Yes ___ No ___	Leukemia	Yes ___ No ___	Liver Disease	Yes ___ No ___
Low Blood Pressure	Yes ___ No ___	Lung Disease	Yes ___ No ___	Osteoporosis	Yes ___ No ___
Mitral Valve Prolapse	Yes ___ No ___	Parathyroid Disease	Yes ___ No ___	Psychiatric Care	Yes ___ No ___
Radiation Treatment	Yes ___ No ___	Recent Weight Loss	Yes ___ No ___	Renal Dialysis	Yes ___ No ___
Rheumatic Fever	Yes ___ No ___	Rheumatism	Yes ___ No ___	Scarlet Fever	Yes ___ No ___
Shingles	Yes ___ No ___	Sickle Cell Disease	Yes ___ No ___	Sinus Trouble	Yes ___ No ___
Spinal Bifida	Yes ___ No ___	Stomach Disease	Yes ___ No ___	Stoke	Yes ___ No ___
Swelling of Limbs	Yes ___ No ___	Thyroid Disease	Yes ___ No ___	Tonsillitis	Yes ___ No ___
Tuberculosis	Yes ___ No ___	Tumors or Growths	Yes ___ No ___	Ulcers	Yes ___ No ___
Venereal Disease	Yes ___ No ___	Yellow Jaundice	Yes ___ No ___	Other ________________________	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to update the office of changes.

Signature of Patient or Guardian ____ Date ___________________