

Medical History

Name *

First Name

Last Name

Email Address *

Phone Number *

Are you currently being treated by a physician for a specific condition?

- Yes No

If so, please tell us about your treatment

Have you recently been hospitalized or had a major operation?

- Yes No

If so, please tell us about the hospitalization

Have you ever had a serious head or neck injury?

- Yes No

If so, please tell us about the head/neck injury

Are you taking any medications, pills, or drugs?

- Yes No

Please list all medications and dosage

Are you on a special diet?

- Yes No

Please tell us about your diet

Do you use tobacco?

- Yes No

Please tell us how often and what type of tobacco consumption

Recreational drug and/or alcohol use, combined with local anesthesia may cause a life-threatening emergency.

Have you ever been advised that you require antibiotics prior to a dental appointment?

- Yes No

Please tell us about the antibiotics

Do you take, or have you taken, PhenFen or Redux?

- Yes No

If so, please tell us about your PhenFen/Redux usage

Have you ever taken Fosomax, Boniva, Actonel or any other medications containing bisphosphonates?

- Yes No

If so, please tell us about your bisphosphonate usage

Have you recently used controlled substances?

- Yes No

If so, please tell us which controlled substances and amount/frequency

Have you recently consumed alcohol?

- Yes No

Please tell how much alcohol and how recently

Please answer if filling this form out on the day of your appointment

Women (Please check all that apply)

- Pregnant Trying to get pregnant
 Currently nursing Taking oral contraceptives
 None of the above

Have you ever had an adverse reaction or allergies to any medication or substance? (Please check if allergic) *

- | | | |
|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Acrylic | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Metal | <input type="checkbox"/> Novocaine | <input type="checkbox"/> Nitrous Oxide |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Valium | <input type="checkbox"/> Xylocaine | <input type="checkbox"/> None of the Above |
| <input type="checkbox"/> Other | | |

If other, please list

Multiple Choice must have at least one option checked

Do you have, or have you ever had any of the following medical conditions? (Please select all that apply) *

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Frequent Cough |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Shingles | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis or Gout | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Congenital Heart Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug/Alcohol Addiction |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Valve or Pacemaker | <input type="checkbox"/> Herpes | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Ulcers or GI Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Heart Attack/Heart Failure |
| <input type="checkbox"/> Hepatitis (B or C) | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Swelling of Limbs | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Dizziness or Fainting |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Hepatitis (A) | <input type="checkbox"/> HIV-AIDS-ARC |
| <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Tumor or Growth | <input type="checkbox"/> X-ray/Chemotherapy | <input type="checkbox"/> No to All |

Do you have any condition or problem, not listed, which we should know about? Please explain

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 inform the dental office of any changes in medical status.

Signature *