**Medical History**

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name & Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last Physical \_\_\_\_\_\_\_\_\_\_\_

Do you have or ever had any of the following? (check all that apply) Preferred Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Heart Problems \_\_Chemical Dependency \_\_Nervous Problems

\_\_High Blood Pressure \_\_Hemophilia \_\_Radiation Treatment

\_\_Infective Endocarditis \_\_Arthritis \_\_Back Problems

\_\_Sinus Problems \_\_Epilepsy \_\_Diabetes

\_\_A.I.D.S. \_\_Headaches \_\_Respiratory Disease

\_\_Stroke \_\_Artificial Heart Valves \_\_Special Diet

\_\_Ulcer \_\_Joint Replacement \_\_Swollen Neck Glands

\_\_Immunosuppressive Disorder \_\_Low Blood Pressure \_\_Hepatitis or Liver Disease

\_\_Psychiatric Care \_\_Chronic Diarrhea \_\_General Allergies

\_\_Blood Disease \_\_Cancer \_\_Circulatory Problems

\_\_Allergies to Anesthetics \_\_Digestive Issues \_\_Kidney Problems

Are you a Tobacco user? \_\_yes \_\_no

In the past, have you been required to take an antibiotic prior to dental treatment for a reason other than infection? \_\_yes \_\_no

If so, for what condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any drug allergies or had an adverse reaction to any medication? \_\_yes \_\_no

If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever responded adversely to medical or dental treatment? \_\_yes \_\_no

If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever or are you taking Osteoporosis or cancer medication? (ex. Actonel, Boniva, Fosamax, Didronel) \_\_yes \_\_no

If so, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of a physician? \_\_yes \_\_no If so, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Are you taking any medications at this time? Please list medications or give the front desk a list. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Is there anything else we need to know about your medical history?

**Women:**

Do you suspect you’re pregnant? \_\_yes \_\_no Are you nursing? \_\_yes \_\_no

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_