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Medical & Dental History Form

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician's name, address, & phone number:

_____

Please indicate if you have experienced any of the following:

☐ * Dental Phobic- TLC	☐ * Gag Reflex	☐ **NO EPINEPHRINE**	☐ AMOX ALLERGY
☐ Alzheimers	☐ Anemia	☐ Angina	☐ Arthritis
☐ Artificial Joints	☐ ArtificialHeartValve	☐ Asthma	☐ Blind
☐ Blood Disease	☐ CODEINE ALLERGY	☐ Cancer/Leukemia	☐ Chemo/Radiation
☐ Chronic Cough	☐ Cold Sores	☐ Congenital Heart Dis	☐ Deaf
☐ Depression	☐ DevelopmentalyDisabl	☐ Diabetes	☐ Drug Addiction
☐ ERYTHRO ALLERGY	☐ Emphysema	☐ Epilepsy	☐ External Pacemaker
☐ Fainting/Dizziness	☐ Glaucoma	☐ HIV +	☐ Head/Neck Injury
☐ Heart Surgery	☐ HeartAttack/Disease	☐ HeartMurmur/Arythmia	☐ Hemophilia
☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C	☐ High Blood Pressure
☐ IODINE ALLERGY	☐ Jaundice	☐ KEFLEX ALLERGY	☐ Kidney Problems
☐ LATEX ALLERGY	☐ Liver Problems	☐ Mitral Vlve Prolapse	☐ Nervous Disorders
☐ OTHER ALLERGY:	☐ On Oxygen	☐ Other-See Chart	☐ PEN-VK ALLERGY
☐ PENCILLIN ALLERGY	☐ Pacemaker	☐ Pregnant	☐ Respiratory Problems
☐ Rheumatic Fever	☐ SULFA ALLERGY	☐ Seasonal Allergies	☐ Sickle Cell Disease
☐ Sinus Problems	☐ Sleep Apnea	☐ Stroke	☐ TYLENOL ALLERGY
☐ Thyroid Problems	☐ Tracheostomy	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ VANCOMYCIN ALLERGY	☐ VICODIN ALLERGY	☐ Vertigo

☐ Please check this box if none of the above applies.

PLEASE LET US KNOW IF YOU HAVE TAKEN BLOOD THINNERS, BISPHOSPHONATE'S (OSTEOPOROSIS), OR HAVE PAGET'S DISEASE, CANCER OR OTHER ILLNESS REQUIRING:

☐ ACTONEL	☐ ACTONALPLUS CA	☐ AREDIA	☐ APIXABAN	☐ ARIXTRA	☐ BONIVA
☐ COUMADIN	☐ DABIGATRAN	☐ DIDRONEL	☐ EDOXABAN	☐ ELIQUIS	☐ FONDAPARINUX
☐ FOSOMAX	☐ FOSOMAX PLUS CA	☐ GRAGMIN	☐ HEPARIN	☐ INNOHEP	☐ JANTOVEN
☐ LOVENOX	☐ PRADAXA	☐ RECLAST	☐ RIVARUXABAN	☐ SAVAYSA	☐ SKELID
☐ WARFARIN	☐ XARELTO	☐ ZOMETA	☐ OTHER		

Do you require a antibiotic treatment for dental procedures? YES / NO
Do you experience shortness of breath? YES / NO
Do your ankles swell during the day? YES / NO
Have you been hospitalized within the last 5 years due to a surgery or illness? YES / NO _____
Do you have any other conditions, diseases, etc., not listed above that we should be aware of? Please list: _____
Are you currently taking any *prescription* or *non-prescription* medications? Please list: _____

WOMEN ONLY: Are you pregnant? YES / NO
If Yes, when is the due date?_____

Are you currently nursing? YES / NO

Are you taking Birth Control? YES / NO

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Response Date: _____