MEDICAL HISTORY FORM

Patient Name_____ **Birthdate**_____ **Date**_____

Please circle appropriate answer (ok to leave blank if you don't understand the question)

Yes No Is your general health good?

Yes No Has there been a change in your health in the last year?

Yes No Are you under the care of a physician? If Yes, name & phone_____

If Yes, what is the condition being treated?_____ Date of last medical exam_____

Yes No Have you been hospitalized or had a serious illness in the last five (5) years?

If Yes, please explain _____

Yes No Have you had problems with prior dental treatment? _____

Date of last dental exam _____

Yes No Are you in pain now? Describe _____

Are you taking, or have you ever taken bone/metastatic disease medication (bisphosphonates)? Yes / No For how long?_____

_____ Zometa (Intravenous/IV)
_____ Aredia (Intravenous/IV)
_____ Reclast (injection 1x/year)
_____ Boniva
_____ Didronel
_____ Actonel
_____ Fosamax

Have you ever had, or currently have, the following: (circle Yes/No)

Y N Cancer or Tumors
Y N Radiation Therapy
Y N Chemotherapy(injections/pills)
Y N Heart Attack, Heart Defects
Y N Heart Trouble
Y N Pacemaker
Y N Prosthetic Heart Valve
Y N Infective Endocarditis
Y N Low Blood Pressure
Y N High Blood Pressure
Y N Frequent Headaches
Y N Diabetes (Type____)
Y N Bleeding/Bruising Problems
Y N Adrenal Disease
Y N Thyroid Disease
Y N Stroke
Y N Osteoporosis
Y N Kidney Disease
Y N Artificial Joint
Y N Arthritis
Y N Allergies/Sinus
Y N Stomach Ulcer
Y N Psychiatric Care
Y N Depression
Y N Seizures
Y N STI (Syphilis, Herpes or Gonorrhea)
Y N HIV/AIDS
Y N Liver Disease/Hepatitis (Type___)
Y N Blood Transfusion
Y N Autoimmune Disorders
Y N Asthma
Y N Tuberculosis, Emphysema or Other Lung Disease

Yes No Allergies to drugs, food or latex? Please list_____

Yes No Are you taking any prescribed or over-the-counter medications? (Include aspirin, vitamins & natural remedies) Please list:

_____

_____

Any disease, problem, or prolonged illness not listed on this form? Yes No Please explain**:**_____

Have you ever used:

Yes No Nicotine: Cigarettes Cigars Pipes Chewing tobacco Vape

How much per day? _____ For how long?_____ Quit date_____

Yes No Cannabis: Smoke Vape Edibles Other **Yes No** Other recreational drugs?_____

Do you currently use: Alcohol? **Yes No** Daily? **Yes No**

<u>Women Only</u>

Yes No Do you use birth control pills? Please list_____

Yes No Are you, or could you be pregnant? If Yes, due date?_____

Yes No Are you nursing?

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications.

Patient Signature _____ Date_____

Dentist Signature _____ Date_____ Hygienist Initials_____

Modified 05.31.2023