



# Health Information

Side 2

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Account No.: \_\_\_\_\_

## Medical History

Have you been under the care of a medical doctor within the past two years? .....Yes No

If yes, for what reasons? \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Are you taking any medications, including over the counter medications such as vitamins or herbals now?.....Yes No

Please list all medications, drugs or pills you are taking now: \_\_\_\_\_

Are you allergic to: Penicillin, Aspirin, Codeine, Latex, metals or any other medications? .....Yes No

Please list all medications or substances you are allergic to: \_\_\_\_\_

Are you taking or have taken Bisphosphonate medications (oral: Fosamax, Boniva, Actonel; IV: Aredia, Zometa).....Yes No

If yes, taken for how long? \_\_\_\_\_

Has a physician or previous dentist ever told you that you need to take antibiotics before dental procedures?.....Yes No

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Heart Attack/Disease/Surgery			Artificial Joints (hip, knee, other)			Hives			Anemia		
Chest pain			Stroke			Sinus Problems			Excessive Bleeding		
Congenital Heart Disease			Kidney Disease			Radiation Therapy			Blood Transfusion		
Rheumatic Fever			Diabetes			Chemotherapy			Fainting or Dizziness		
Heart Murmur			Thyroid Problems			Cancer (Type: )			Epilepsy or Seizures		
Mitral Valve Prolapse			Stomach problems or ulcers			Hepatitis (Type: )			Diet pills such as Fen-Phen, Redux		
Artificial Heart Valve			Cortisone medicine			Venereal Disease			Alcohol/Chemical Abuse		
Heart Pacemaker			Asthma			H.I.V. Positive or A.I.D.S.			Psychiatric/Psychological Care		
High Blood Pressure			Lung Disease			Liver Disease			Diseases, conditions or problems not listed:		
Arthritis			Tuberculosis (TB)			Contact Lenses					

Women	Y	N		Y	N
Are you pregnant or possibly pregnant?			Are you taking birth control pills?		
If pregnant, estimated delivery date: / /			Week #	Are you nursing?	

**Note: Antibiotics may decrease the effectiveness of birth control pills. Please consult your physician regarding additional methods of birth control in case you are prescribed any antibiotic medication.**

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.*

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical History Reviewed by (Health Care Provider): \_\_\_\_\_ Date: \_\_\_\_\_

### Medical Updates:

Date: \_\_\_\_\_ Changes: \_\_\_\_\_ Patient/Guardian: \_\_\_\_\_ HCP: \_\_\_\_\_

Date: \_\_\_\_\_ Changes: \_\_\_\_\_ Patient/Guardian: \_\_\_\_\_ HCP: \_\_\_\_\_