MEDICAL HISTORY

Date: _____Name: _____ Date of Birth:_____ Gender: M F

Home Address: _____City:_____State:_____Zip:_____

Primary Phone #:( )_____ h /c /w **Secondary #:**( )_____ h /c /w **SS#_____**

Employer: _____ Occupation: _____ Email:_____

Emergency Contact Name:_____ **Relation:**_____

Primary Phone #:( )_____ h /c /w **Secondary Phone:**( )_____ h /c /w

How did you hear about us? Commercial Insurance Internet Family/Friend/Co-worker_____

Physician's Name:____ _____Phone #:( )_____Date of last visit:_____
Do you smoke or use tobacco in any other form? YES NO
For Women: Are you Pregnant? YES NO Are you nursing? YES NO Are you taking birth control pills? YES NO
Have you ever been advised by a physician that you should premedicate with antibiotics for dental treatment? YES NO

Have you ever or do you now have any of the following medical conditions? Please circle. (Y=Yes, N=No)

Y N Abnormal Bleeding
Y N Anemia
Y N Sickle Cell Disease/Traits
Y N Hemophilia Type?_____
Y N Blood Transfusion
Y N Gastric Ulcers
Y N Arthritis
Y N Osteoporosis
Y N Artificial Joints When?_____
Y N Cancer/Chemotherapy
Y N Radiation Treatment
Y N TMJ/TMD
Y N Frequent Headaches/Migraines
Y N Epilepsy / Fainting Spells
Y N Seizures Last/Type? _____
Y N Thyroid Problem

Y N Heart Disease
Y N High Blood Pressure
Y N Low Blood Pressure
Y N High Cholesterol
Y N Stroke When?_____
Y N Heart Attack When?_____
Y N Heart Surgery When?_____
Y N Cardiac Stent When?_____
Y N Pacemaker When?_____
Y N Heart Murmur
Y N Congenital Heart Disease / Prosthetic Cardiac Valve/ Previous Infective Endocarditis/ Palliative Shunt or Conduit

Y N Bisphosphonate use? Oral or IV? (e.g. Fosomax, Actonel, Boniva, Zometa)
Y N Alcohol/Drug Abuse
Y N Hepatitis Type? _____
Y N HIV / AIDS
Y N Tuberculosis (TB)
Y N Herpes/Fever Blisters/Cold sores
Y N Kidney Problems/Disease
Y N Liver Disease
Y N Psychiatric Problem
Y N Diabetes
Y N Insulin Dependent
Y N Difficulty Breathing
Y N Asthma
Y N Emphysema

Any other medical condition(s)? YES NO If yes, please explain:_____

_____

Any prescription, over-the-counter, herbal or natural supplements? YES NO If yes, please list:_____

_____

Do you have any allergies to medications? YES NO If yes, please circle:

Penicillin	Codeine	Metals	Keflex	Levaquin
Latex	Erythromycin	Tetracycline	Doxycycline	Motrin/Advil (ibuprofen)
Dental Anesthetics	Epinephrine	Clindamycin	Iodine	Z-Pack (azithromycin)

Please list any other drugs/materials to which you are allergic: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform my provider of any changes in my medical status.

Patient/Guardian Signature:_____ Date:_____

For office use only:

Date: _____ Initials: _____ Comments: _____
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