

# 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 #:( ) \_\_\_\_\_ h /c /w  
Person Responsible for Account: \_\_\_\_\_ SS# \_\_\_\_\_ Relation: \_\_\_\_\_

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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 Heart Disease	Y N Bisphosphonate use? Oral or IV? (e.g. Fosomax, Actonel, Boniva, Zometa)
Y N Anemia	Y N High Blood Pressure	Y N Alcohol/Drug Abuse
Y N Sickle Cell Disease/Traits	Y N Low Blood Pressure	Y N Hepatitis Type? _____
Y N Hemophilia Type? _____	Y N High Cholesterol	Y N HIV / AIDS
Y N Blood Transfusion	Y N Stroke When? _____	Y N Tuberculosis (TB)
Y N Gastric Ulcers	Y N Heart Attack When? _____	Y N Herpes/Fever Blisters/Cold sores
Y N Arthritis	Y N Heart Surgery When? _____	Y N Kidney Problems/Disease
Y N Osteoporosis	Y N Cardiac Stent When? _____	Y N Liver Disease
Y N Artificial Joints When? _____	Y N Pacemaker When? _____	Y N Psychiatric Problem
Y N Cancer/Chemotherapy	Y N Heart Murmur	Y N Diabetes
Y N Radiation Treatment	Y N Congenital Heart Disease / Prosthetic Cardiac Valve/ Previous Infective Endocarditis/ Palliative Shunt or Conduit	Y N Insulin Dependent
Y N TMJ/TMD		Y N Difficulty Breathing
Y N Frequent Headaches/Migraines		Y N Asthma
Y N Epilepsy / Fainting Spells		Y N Emphysema
Y N Seizures Last/Type? _____		
Y N Thyroid Problem		

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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