Patient Medical History

Today's date ___/___/___

Last Name _____First Name _____MI _____

Male _____ Female _____Date of Birth _____/_____/_____

Who is your primary care physician? _____

Are you currently receiving treatment for a medical condition? ☐ yes ☐ no
*If yes, explain*_____

Have you ever had a major operation or serious illness? ☐ yes ☐ no
*If yes, explain*_____

Are you taking blood thinners such as **Coumadin**, **Plavix** or **Aspirin**? *(circle one)* ☐ yes ☐ no

Are you taking any medications? *(including oral contraceptives and non-prescription medicines)* ☐ yes ☐ no

Current medications (list all)_____

_____

Are you allergic to or have you had any unusual reactions to any medications? ☐ yes ☐ no
*If yes, what medications are you allergic to?*_____

Have you ever taken **Fosamax** or any other drug for osteoporosis? ☐ yes ☐ no

Are you currently pregnant? _____ If yes, due date? _____Are you currently nursing?_____

Do you have or have you ever had any of the following? Yes_____ No_____

- ☐ Anemia
- ☐ Angina
- ☐ Artificial Heart Valves
- ☐ Asthma/COPD
- ☐ Cancer
- ☐ Cardiac Pacemaker
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy / Seizures
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis A, B, C (circle one)
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ HIV+/AIDS
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Lupus
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis

Notes: _____

Are you currently in pain? ☐ yes ☐ no

Do you need to pre-medicate with an antibiotic before your dental treatment? ☐ yes ☐ no

Have you ever had serious/difficult problems associated with any previous dental work? ☐ yes ☐ no

Have you been treated for gum disease and/or periodontal disease? ☐ yes ☐ no

Have you ever experienced pain/discomfort in your jaw joint (TMJ)? ☐ yes ☐ no

Do you smoke or use other tobacco products? If so, how much? _____ pack / day ☐ yes ☐ no

Your current dental health is ☐ *Good* ☐ *Fair* ☐ *Poor*

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. <u>I understand that a 24 hour notice of cancellation is required. Failure to do so could result in a fee and/or being dismissed as a patient.</u>

Rev 2/14

Signature: _____ ***Date:*** _____