MEDICAL HISTORY

Physician's Name_____ Date of last visit_____
Are you in general good health? Yes No If No, explain_____
Have you had any serious illnesses or surgeries? Yes No If yes, explain_____
(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No
Check if you have or have had any of the following:

Allergies	Chemical Dependency	Hepatitis Type_____	Rheumatic Fever
Anemia	Cough, Persistent	High Blood Pressure	Scarlet Fever
Arthritis, Rheumatism	Cough up Blood	HIV/AIDS	Shortness of Breath
Artificial Heart Valves	Diabetes	Excessive Bleeding	Skin Rash
Artificial Joint	Epilepsy or Seizures	Kidney Disease	Stroke
Asthma	Fainting Spells	Liver Disease	Swelling of Ankles
Back Problems	Glaucoma	Mitral Valve Prolapse	Thyroid Disease
Bleeding Problems	Herpes	Nervous Problems	Tobacco Habit
Blood Disease	Heart Murmur	Pacemaker	Tonsillitis
Cancer	Heart Problems	Psychiatric Care	Tuberculosis
Chemotherapy	Describe_____	Radiation Treatment	Ulcer
Describe_____	Bleeding Problems	Persistant Cough	Severe Weight Loss
Circulatory Problems	Hemophilia	Respiratory Disease	STD
Congenital Heart Disease	Osteoporosis	Seizures	Sinus Problem
Chest Pain	Stomach Problems/Ulcer	Skin Disease	Other_____

Do you have or have you had any other diseases or medical problems NOT listed above? Yes No If Yes, explain_____

DENTAL HISTORY

Sensitive Teeth to Cold	Teeth Grinding/Clenching	Dry Mouth	Difficulty Opening Mouth
Sensitive Teeth to Hot	Teeth Pain to Biting	Headaches	Canker or Cold Sores
Sensitive Teeth to Sweets	TMJ Pain	Jaw Pain	Other_____

Have you ever been pre-medicated for dental treatment? Yes No If Yes, why:_____

MEDICATIONS

List medications you are currently taking: ☐ NONE
High Blood Pressure Blood Thinner Antibiotics
Aspirin Pain Medication Fosamax
List_____
_____
_____
_____
_____
Pharmacy_____

ALLERGIES

Check medications you are allergic to: ☐ NONE

Aspirin / Ibuprofen	Penicillin/Amoxicillin
Codeine	Erythromycin
Vicodin/Hydrocodone	Clindamycin
Sulfa Drugs	Percodan
Valium	Food
Local Anesthetic	Latex
Metals _____	Barbiturates
Other_____	(Sleeping Pills)

MEDICAL HISTORY UPDATE

(To be filled in at future appointments)

Date_____	Date_____	Date_____	Date_____
Health Changes_____	Health Changes_____	Health Changes_____	Health Changes_____
_____	_____	_____	_____
Patient's Initials_____	Patient's Initials_____	Patient's Initials_____	Patient's Initials_____
Dentist Initials_____	Dentist Initials_____	Dentist Initials_____	Dentist Initials_____

SIGNATURE

I certify that I have read and understand this form. 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 medication. Further, I will not hold my dentist, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient_____ Date_____

Signature of Dentist_____ Date_____