



Medical Information

Name: _____ Date of Birth: ____/____/____ Current Age: _____

All information on this form as well as any additional information provided to your doctor will be held in the strictest confidence. It will not be disclosed to anyone outside this office without your permission. The following questions relate directly to safe and effective dental care. Please answer them honestly to the best of your ability. If you are unsure about a question, or how to answer it, please discuss it with your doctor.

Physician's Name: _____ Phone: _____

Address: _____ Date of last visit: _____

Have you ever been hospitalized? ___ Yes ___ No. If yes, condition/date: _____

Have you taken any medications within the past year? ___ Yes ___ No. If yes, please list all medications and medical conditions being treated: _____

Are you taking any over the counter medications? ___ Yes ___ No. If yes, please list: _____

Do you premedicate prior to dental treatment? ___ Yes ___ No. If yes, please state reason and medication: _____

Are you taking Coumadin (Warfarin), Plavix, aspirin or any other blood thinners? ___ Yes ___ No

Are you taking any Bisphosphonate medications? (Fosamax, Boniva, Actonel, Zometa, Aredia, Skelid, Bonafos, Ostac, Didronel, Loron, Reclast, etc.) ___ Yes ___ No. If yes, state reason, length of time and in what form - (pills vs. injections): _____

Check any of the following you currently have or have had in the past:

- | | | |
|---|--|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Murmur/Mitral Valve Prolapse | <input type="checkbox"/> Pain in Jaw Joints/Dislocation
(Clencher, Grinder, Bruxer?) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Hemophilia/Sickle Cell | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis Non A/Non B | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic Cough/Bronchitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Transplants-kidney, etc. |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immunological Disease | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Injury to Face, Jaw or Teeth | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Knee, Hip, etc. Replacements/Implants | |

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Check any of the following you are allergic to or have had any reactions to:

- | | | |
|--|---|--|
| <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Darvon | <input type="checkbox"/> Percodan/Percocet |
| <input type="checkbox"/> Anti-Inflammatories
(Motrin, Advil, Aleve, etc.) | <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Cephalosporins | <input type="checkbox"/> Local Anesthetic (Lidocaine, etc.) | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Nitrous Oxide | |
| | <input type="checkbox"/> Penicillin | |

Are you aware of being allergic to any other medication or substance? Yes No. If yes, please list:

Is there anything regarding your medical condition not covered above that you feel the doctor should know about? Yes No. If yes, what? _____

WOMEN ONLY

Are you pregnant or planning pregnancy? Yes No. If pregnant, number of weeks: _____

Obstetrician and Phone: _____

Are you nursing? Yes No Are you taking birth control* at this time? Yes No

*Antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Please understand an additional form of birth control for one complete cycle will be needed after the course of antibiotics or other medications are completed.

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature: _____ Date: _____

Updated: _____

