Medical History Form

Name: _____ DOB:_____ Today's Date:_____

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental care you will receive.

Who is/are your phyician(s) currently?		
Have you ever been hospitalized or had a major operation?	Yes No	If yes:
Have you ever had a serious head or neck injury?	Yes No	If yes:
Are you taking any prescriptions, pills, vitamins, or over-the-counter drugs?	Yes No	If yes:
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes:
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	Yes No	If yes:
Are you on a special diet?	Yes No	If yes:
Do you use tobacco or vape?	Yes No	If yes:
Do you use controlled substances?	Yes No	If yes:
Have you have received your COVID-19 vaccination?	Yes No	If yes:
*If yes, please list when you have received your 1st & 2nd dose?		

Women: Are you?...

Pregnant/Trying to get pregnant?	Yes No
Nursing?	Yes No
Taking oral contraceptives?	Yes No

Are you allergic to any of the following?...

Aspirin	Yes No	Metal	Yes No
Penicillin	Yes No	Latex	Yes No
Codeine	Yes No	Sulfa Drugs	Yes No
Arylic	Yes No	Local Anesthetics	Yes No
Other?			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

x _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Hemophilia	Yes	No
Alzheimer	Yes	No	Hepatitis A	Yes	No
Anaphylaxis	Yes	No	Hepatitis B or C	Yes	No
Anemia	Yes	No	Herpes	Yes	No
Angina	Yes	No	Hearing Loss	Yes	No
Arthritis/Gout	Yes	No	High Blood Pressure	Yes	No
Artificial Heart Valve	Yes	No	High Cholesterol	Yes	No
Artificial Joint	Yes	No	Hives or Rash	Yes	No
Asthma	Yes	No	Hypoglycemia	Yes	No
Blood Disease	Yes	No	Irregular Heartbeat	Yes	No
Blood Transfusion	Yes	No	Kidney Problems	Yes	No
Breathing Problems	Yes	No	Leukemia	Yes	No
Bruise Easily	Yes	No	Liver Disease	Yes	No
Cancer	Yes	No	Low Blood Pressure	Yes	No
Chemotherapy	Yes	No	Lung Disease	Yes	No
Chest Pains	Yes	No	Mitral Valve Prolapse	Yes	No
Cold Sores/Fever Blisters	Yes	No	Osteoporosis	Yes	No
Congenital Heart Disorder	Yes	No	Pain in Jaw Joints	Yes	No
Convulsions	Yes	No	Parathyroid Disease	Yes	No
Cortisone Medicine	Yes	No	Psychiatric Care	Yes	No
COVID-19	Yes	No	Radiation Treatments	Yes	No
Dementia	Yes	No	Recent Weight Loss	Yes	No
Diabetes	Yes	No	Renal Dialysis	Yes	No
Drug Addiction	Yes	No	Rheumatic Fever	Yes	No
Easily Winded	Yes	No	Rheumatism	Yes	No
Emphysema	Yes	No	Scarlet Fever	Yes	No
Epilepsy or Seizures	Yes	No	Shingles	Yes	No
Excessive Bleeding	Yes	No	Sickle Cell Disease	Yes	No
Excessive Thirst	Yes	No	Sinus Trouble	Yes	No
Fainting Spells/Dizziness	Yes	No	Spina Bifida	Yes	No
Frequent Cough	Yes	No	Stomach/Intestinal Disease	Yes	No
Frequent Diarrhea	Yes	No	Stroke	Yes	No
Frequent Headaches	Yes	No	Swelling of the Limbs	Yes	No
Genital Herpes	Yes	No	Thyroid Disease	Yes	No
Glaucoma	Yes	No	Tonsillitis	Yes	No
Hay Fever	Yes	No	Tuberculosis	Yes	No
Heart Attack/Failure	Yes	No	Tumors or Growths	Yes	No
Heart Murmur	Yes	No	Ulcers	Yes	No
Heart Pacemaker	Yes	No	Venereal Disease	Yes	No
Heart Trouble/Disease	Yes	No	Yellow Jaundice	Yes	No
Other?					