Patient Medical History

Name: _____ **Birthdate:** _____

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 _____

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 or nursing? ❍ yes ❍ no

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

- ❍ 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
- ❍ High / 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: _____

Why have you come to the dentist today? _____

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. 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.

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

Update ___/___/___ Changes: _____

Update ___/___/___ Changes: _____

Update ___/___/___ Changes: _____