Patient Medical History

Patient Name: _____ Today's Date: _____

Medical Information

Are you currently under the care of a Physician? ☐ Yes ☐ No

Physician's Name: _____ Phone: _____ Date of last exam: _____

Physician's Address: _____ City:_____ State: _____ Zip: _____

Have there been any changes in your general health within the past year? ☐ Yes ☐ No

If yes, what was the illness or problem? _____

_____

WOMEN ONLY Are you:

Pregnant? (Number of Weeks _____) ☐ Yes ☐ No

Taking birth control pills or hormonal replacement? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Premedication Information

Has a previous physician or dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

Physician/ Dentist Name: _____ Type of antibiotic: _____

Joint Replacement

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ Yes ☐ No

Date of surgery: _____ If yes, have you had any complications? ☐ Yes ☐ No

Have you ever taken: Fosamax, Boniva, Actonel, Prolia or any other medication containing bisphosphate? ☐ Yes ☐ No

Are you currently taking blood thinner? ☐ Yes ☐ No

Do you use controlled substances (drugs)? ☐ Yes ☐ No

Do you use tobacco or vape (smoking, snuff, chew, bidis)? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ Yes ☐ No

Please list all medications, including vitamins, natural or herbal preparations and/or dietary supplements:

☐ **(✓) if you provided office with a list of current medications.**

Please complete back of form

Update 1/24

Patient Medical History

Allergies

Please (✓) if you have any of the following allergies:

- ☐ Local Anesthetics
- ☐ Latex (Rubber)
- ☐ Sulfites (Preservatives)
- ☐ Penicillin / Amoxicillin
- ☐ Tetracycline
- ☐ Sulfa Drugs (Antibiotics)
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Benzocaine
- ☐ Chlorhexidine
- ☐ Hydrocodone
- ☐ Codeine or other narcotics
- ☐ Oxycodone
- ☐ Iodine
- ☐ Metals
- ☐ Animals
- ☐ Hay Fever / Seasonal
- ☐ Aspirin
- ☐ Tylenol

Please (✓) if you have or have had any of the following:

- ☐ Artificial (Prosthetic) heart valve
- ☐ Previous infective endocarditis
- ☐ Damaged valves in transplanted heart
- ☐ Cardiovascular disease
- ☐ Angina
- ☐ Damaged heart valve
- ☐ Heart attack (Date: _____)
- ☐ Asthma
- ☐ Emphysema
- ☐ Sinus trouble
- ☐ Diabetes Type I ☐ or Type II ☐
- ☐ Stroke (Date: _____)
- ☐ Sleep disorder
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Abnormal bleeding
- ☐ Bronchitis
- ☐ Chest pain upon exertion
- ☐ Chronic pain
- ☐ Eating disorder
- ☐ Fainting spells or seizures
- ☐ Snoring
- ☐ Hemophilia
- ☐ AIDS or HIV infections
- ☐ Severe headaches / migraines
- ☐ Severe or rapid weight loss
- ☐ Thyroid problems ☐ Hyper or ☐ Hypo
- ☐ Autoimmune disease
- ☐ Rheumatoid arthritis
- ☐ Cancer/Chemotherapy/Radiation
- ☐ Ulcers
- ☐ Osteoporosis
- ☐ GE Reflux / persistent heartburn
- ☐ Hepatitis, jaundice, or liver disease
- ☐ Kidney problems
- ☐ Congenital heart disease (CHD)
  - ☐ Unrepaired, cyanotic CHD
  - ☐ Repaired CHD with residual defects
  - ☐ Repaired (completely) in last 6 months

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.

Signature of Patient/Parent/ Legal Guardian Relationship Date