Medical History

Patient's Name ____
Name of *medical doctor* ____
Date of last physical ____

Name of *previous dentist* ____
Date of last exam ____

	Yes	No
*Are you currently under the care of a physician?	○	○
If so, for what? ____		
* Has there been any change in your health within the past year? ____	○	○
*Have you ever had or been diagnosed with:		
Infective endocarditis	○	○
Congenital heart defect	○	○
High blood pressure	○	○
Low blood pressure	○	○
High cholesterol	○	○
Prosthetic joint surgery	○	○
Prosthetic heart valve	○	○
Heart surgery	○	○
Pacemaker/defibrillator	○	○
Anticoagulant therapy	○	○
Heart attack	○	○
Organ transplant	○	○
Emphysema/sarcoidosis	○	○
Asthma	○	○
Tuberculosis	○	○
Anemia	○	○
Blood problems	○	○
Leukemia	○	○
Diabetes (HbA1c=____)	○	○
Thyroid disorder	○	○
Ulcer, colitis	○	○
Hepatitis	○	○
Liver disease	○	○
Kidney trouble	○	○
Arthritis, Rheumatism	○	○
Malignancies/cancer	○	○
Chemotherapy	○	○
Venereal disease	○	○
Epilepsy/convulsions	○	○
Neurological issues	○	○
Drug/alcohol dependency	○	○
Excessive bleeding(INR>3.5)	○	○
Stroke (blood thinners?)	○	○
Corticosteroid therapy	○	○
Fainting spells, convulsions	○	○
Psychiatric care	○	○
Head & neck radiation	○	○
Eye disorder (glaucoma)	○	○
Hormone therapy	○	○
HIV/AIDS	○	○

	Yes	No
Have you ever taken the drug Fen-Phen?	○	○
Do you have osteoporosis?	○	○
Have you ever taken bisphosphonates such as: Fosamax, Actonel, Aredia, Zometa, Boniva, Didronel, Skelial, etc to prevent bone loss from osteoporosis?	○	○
Do you have any disease, condition or problem not listed? ____		
Do you wear, or have you worn a **CPAP**?	○	○
Do you snore or have sleep apnea?	○	○
Do you often feel exhausted or fatigued?	○	○
Do you have any specific dental concerns	○	○
If so, what ____		
Any lumps or swelling in the mouth?	○	○
Would you like to keep your remaining teeth?	○	○
Do you smoke or chew tobacco?	○	○
Amount ____ How many years ____		

For Women:

	Yes	No
Is there any chance you could be pregnant?	○	○
Are you taking birth control pills?	○	○

Please list any and all medications you are taking, including herbal supplements?

Drug	Purpose

	Yes	No
* Any known **allergies**?	○	○
Specifically, Penicillin	○	○
Sulfa	○	○
Latex	○	○

*****Signature** **(patient or parent/guardian)**

____ **Date** ____

Today's Date ______________

Patient's Date of Birth ______________ Patient's Social Security # ______________

Home phone ______________ Work phone ______________ Cell ______________

Address ______________ City ______________ State ________ Zip ________

Your Email Address (will not be given out, office use only) ______________

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If student, name of school/college ______________ City ______________ State ________

We require the name and phone number of an emergency contact in the event of a medical Emergency.

Name & Relationship	**Phone number**

Who may we thank for this referral or how did you hear about our office? ______________

For Dental Insurance Purposes only: (This information will aid in the submission of insurance)

Employee's Name (Subscriber)	**DOB**	**SS# (or ID #)**

Dental Insurance Company	**Insurance Phone number**	**Employer**

(FOR FUTURE USE)

PLEASE UPDATE ANY CHANGES TO YOUR HEALTH OR PERSONAL INFORMATION

Date	Changes	Signature