Medical History Form

Patient Name: _____ **Birth Date:** _____ **Date Created:** _____

Have you ever had dental anxiety or a negative dental experience?	Yes No	If yes
Do you currently take antibiotic premedication for dental visits?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Are you under a physician's care now?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Are you taking any vitamins or herbal supplements?	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
Do you use tobacco?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes

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

Acid Reflux Yes No	Cold Sores/Fever Blisters Yes No	Lung Disease Yes No	AIDS/HIV Positive Yes No
Heart Trouble/Disease Yes No	Oral Cancer Yes No	Alcoholism Yes No	Diabetes Yes No
Hemophilia Yes No	Osteoporosis Yes No	Alzheimer's Disease Yes No	Drug Addiction Yes No
Hepatitis B or C Yes No	Pain in Jaw Joints Yes No	Anxiety Yes No	Emphysema Yes No
Psychiatric Care Yes No	Artificial Joint Yes No	Epilepsy or Seizures Yes No	High Blood Pressure Yes No
Sinus Trouble Yes No	Asthma Yes No	Excessive Bleeding Yes No	HPV Yes No
Stroke Yes No	Breathing Problems Yes No	Fainting Spells/Dizziness Yes No	Hypoglycemia Yes No
Tonsillitis Yes No	Cancer Yes No	Frequent Cough Yes No	Joint Replacement Yes No
Tuberculosis Yes No	Chemotherapy or Radiation Therapy Yes No	Heart Attack/Failure Yes No	Tumors or Growths Yes No
Chest Pains Yes No	Heart Pacemaker Yes No	Low Blood Pressure Yes No	Ulcers Yes No

Have you ever had any serious illness not listed above?	Yes No	If yes

Commments/Specifications

Woman: 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	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics
Other			

How would you rate your sugar intake?

Low	Moderate	High

How would you rate your acidity exposure? (wine, coffee, citrus, soda, sparkling water, etc.)

Low	Moderate	High

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.

Signature of Patient, Parent or Guardian:

X Date:_____