



# MEDICAL HISTORY

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Marital Status \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email \_\_\_\_\_

Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Home/Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Former Dentist \_\_\_\_\_ How Long? \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Physician \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Referred By: \_\_\_\_\_ Reason: \_\_\_\_\_

Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

1. Have you had any medical care or surgeries within the past two years?.....  Yes  No  
Describe \_\_\_\_\_

2. Are you currently **taking any medication, drugs, pills, or herbal remedies**, including regular dosages of aspirin?  Yes  No  
**If Yes, please list:** \_\_\_\_\_

3. Do you use Tobacco/Nicotine in any form?  Smoke  Chewing  E-cigs/Vape  Other Form  Yes  No

4. Have you ever taken bone loss prevention drugs such as **Fosamax, Actonel, Boniva**, or other similar drugs?.....  Yes  No

5. Have you **EVER had an ADVERSE or ALLERGIC reaction** to any substance or medication?.....  Yes  No

**If Yes, please specify** \_\_\_\_\_

6. Have you ever been diagnosed and/or treated for Sleep Apnea?  Yes  No

7. Do you have any of the following symptoms?  Daytime Sleepiness  Snoring  Waking Gasping for Air

8. Indicate **which** of the following **you have had**, or **have at present**. Check "Yes" or "No" to each item:

- |   |   |   |
|---|---|---|
| Heart..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   | Kidney Problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | Hepatitis A, B, C..... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| (Surgery, Disease, Attack)  | Thyroid Problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No        | AIDS/HIV Positive..... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Chest Pain..... <input type="checkbox"/> Yes <input type="checkbox"/> No              | Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No                | Cold Sores/Fever Blisters..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Congenital Heart Problems.. <input type="checkbox"/> Yes <input type="checkbox"/> No  | Glaucoma..... <input type="checkbox"/> Yes <input type="checkbox"/> No                | Dry Mouth..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   |
| High/Low Blood Pressure.... <input type="checkbox"/> Yes <input type="checkbox"/> No  | Emphysema..... <input type="checkbox"/> Yes <input type="checkbox"/> No               | Difficulty Swallowing..... <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| Artificial Heart Valve..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No            | Hemophilia/Bleeding Disorder.... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pacemaker/Defibrillator..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No                  | Liver Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| Cortisone Medication..... <input type="checkbox"/> Yes <input type="checkbox"/> No    | Hay Fever/Allergy/Hives... <input type="checkbox"/> Yes <input type="checkbox"/> No   | Neurological Disorders..... <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No                  | Latex Sensitivity/Allergy... <input type="checkbox"/> Yes <input type="checkbox"/> No | Alzheimers or Dementia..... <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Artificial Joints..... <input type="checkbox"/> Yes <input type="checkbox"/> No       | Sinus Trouble..... <input type="checkbox"/> Yes <input type="checkbox"/> No           | Epilepsy or Seizures..... <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| (Hip, Knee, etc.)   | Radiation Therapy..... <input type="checkbox"/> Yes <input type="checkbox"/> No       | Fainting or Dizzy Spells..... <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Osteoporosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No            | Chemotherapy..... <input type="checkbox"/> Yes <input type="checkbox"/> No            | Nervous/Anxious..... <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Arthritis/Joint Pain..... <input type="checkbox"/> Yes <input type="checkbox"/> No    | Tumors/Cancer..... <input type="checkbox"/> Yes <input type="checkbox"/> No           | Psychiatric/Psychological   |
| Organ Transplant..... <input type="checkbox"/> Yes <input type="checkbox"/> No        | Autoimmune Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No      | Care..... <input type="checkbox"/> Yes <input type="checkbox"/> No                        |

9. Do you have or have you had any disease, condition, or problem not listed?  Yes  No  
If Yes, please specify \_\_\_\_\_

10. Women: Are you Pregnant or think you could be pregnant?  Yes, \_\_\_ Months  No Nursing?  Yes  No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medications.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Comments:

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_