Medical/Dental History

Patient Name: _____ Date of Birth: _____
Physician's Name: _____ Physician's Phone Number: _____
Pharmacy phone number: _____
Are you in good health at this time? …… YES NO
Are you taking any prescriptions, blood thinners, over the counter medications or herbal supplements…… YES NO
If yes, please list them:

_____

Are you allergic to any medications (e.g. codeine, penicillin, sulfa, etc.)? …… YES NO
If yes, please list them:

_____

Have you had local anesthetics (Novocaine) for dental work? …… YES NO
If yes, any adverse reactions? …… YES NO
Women: Are you pregnant? …… YES NO
Are you nursing? …… YES NO
Are you using hormonal birth control? …… YES NO
PLEASE CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR CURRENTLY HAVE:

Cancer	Hepatitis (please specify type)	Blood Clots
Easy Bruising	_____	Allergies to metals
Heart Problems/Surgeries	Diabetes	Allergy to latex
Radiation or Chemotherapy	Asthma/Respiratory Problems	Use of Tobacco products
Ulcers	Anemia	Sore spots in mouth
High Blood Pressure	Arthritis/Rheumatoid	Pain in Jaw Joint or near ears
Epilepsy/Seizures	Drug or Alcohol Addiction	Clench or Grind Teeth
Mental Health Problems	Wear Contact Lenses	Sensitive to hot/cold
Artificial Heart Valve	Glaucoma	Sensitive to sweet
Cold Sores	Tuberculosis	Sensitive to bite pressure
Thyroid Problems	Bleeding Problems	Bleeding Gums
Kidney or Liver Problems	Sinus Problems	Dental Phobia
Stroke	AIDS/HIV	
Joint Replacements	Positive STD's/STI's	
Osteoporosis	Circulatory Problems	

Please describe any past or current medical condition that may possibly affect your dental treatment:

_____

_____ I hereby certify that I have answered all questions on this form truthfully and, to the best of my knowledge, have not omitted anything. I understand that providing incorrect information can be dangerous to my health.

All information is HIPPA compliant and will only be disclosed for medical or dental treatment.

Patient/Guardian Signature:_____

Date:_____