Medical History

Patient Name: ____ Date: ___________________________

Approximately how long has it been since your last dental visit? __________________________________

Reason for this visit? ____

Are you **allergic** to any medication? Yes ______ No ______

If yes, name of medication(s): ____

Have you ever responded adversely to dental anesthetic? Yes ______ No ______

Have you ever been told to be pre-medicated with antibiotic treatment? Yes ______ No ______

Women: Are you pregnant? Yes ______ No ______ If yes, due date: ______________________

Medications: (Prescribed and Over the Counter)	**Reason:**

***If you have a list, please turn it in to the receptionist for a copy. *If more space is needed, please write on back of page.**

Do you take any blood thinners, aspirin, or fish oil **daily**? If yes, list the name of medication(s):

____

Are you **presently** under the care of a physician? Yes ______ No ______

If yes, for what condition? ____

Name of Physician: ____________________________________ Phone #: ____________________

Health Information

Have you **ever** had any of the following? Please check all that apply:

_ Anemia
_ Arthritis
_ Artificial Heart
_ Artificial Hip
_ Artificial Knee
_ Artificial Joints
_ Asthma
_ Back Problems
_ Blood Disease
_ Cancer
_ Chemical Dependency
_ Diabetes
_ Dizziness
_ Epilepsy
_ Excessive Bleeding
_ Fainting
_ Glaucoma
_ Head Injuries
_ Heart Disease
_ Heart Murmur
_ Heart Stent
_ Hepatitis
_ Hemophilia
_ High Blood Pressure
_ HIV Positive
_ AIDS
_ Kidney Disease
_ Liver Disease
_ Mental Disorders
_ Mitral Valve Prolapse
_ Pacemaker
_ Radiation Treatment
_ Respiratory Problems
_ Rheumatic Fever
_ Rheumatism
_ Sleep Medication
_ Smoker
_ Stomach Problems
_ Stroke
_ Tuberculosis
_ Tumors
_ Ulcers
_ Venereal Disease
_ Codeine Allergy
_ Penicillin Allergy
_ Other: ______________
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The information above is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

____ ____

Signature Date