MEDICAL HISTORY

PERSONAL INFORMATION

Name: _____ _____ _____
Last First Preferred Name

DENTAL HISTORY

Date of your last Dental Exam? _____

What is your primary reason for today's visit? _____

MEDICAL HISTORY

Date of last medical exam: _____**Name Medical Physician:** _____**Ph#**_____

Are you currently being treated by a physician? _____

Do you have any allergies? _____

Please list any medications or supplements you are taking: _____

_____

Have you ever had the following diseases or medical conditions? **PLEASE CIRCLE (YES/NO)**

Y / N Diabetes: Type ____
Y / N Autoimmune Disease
Y / N Rheumatic Fever
Y / N Chest Pain/Angina
Y / N Heart Murmur
Y / N Stroke
Y / N High Blood Pressure
Y / N Heart Attack
Y / N Bleeding Problems/Disorder
Y / N Breathing or Sleep Problems (sleep apnea/snoring/sinus)
Y / N Asthma
Y / N Lung Disease
Y / N Tuberculosis

Y / N Hepatitis/Jaundice/Liver Disease
Y / N Kidney Disease
Y / N Thyroid Disease (Hypo- or Hyper-)
Y / N Anxiety/Depression
Y / N Seizures
Y / N Epilepsy
Y / N Arthritis
Y / N Osteoporosis
Y / N Cancer
Y / N AIDS/HIV Infection
Y / N GI Disturbances (Crohn's/colitis/ulcers)
Y / N Cold sores ***please re-schedule appointment**

Y / N Have you been told you need **pre-medication** before any dental treatment?
Y / N Any **other** medical concerns not listed above? Please list.

_____

Have you ever received the following treatments?

Y / N Prosthetic Heart Valve
Y / N Pacemaker
Y / N Chemotherapy
Y / N Radiation Therapy
Y / N Prosthetic or Artificial Joint(s) (hip/knee replacements)

Do you use any of the following?

Y / N Nicotine/Tobacco/Cannabis products
Y / N Drug/Alcohol Dependency

Is there any chance you are currently pregnant?

Y / N ____ weeks (if known)

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Patient/Parent/Guardian Signature: _____ **Date:** _____