Medical History

Name of your personal physician_____ Date of last visit_____

Physician's address_____ Phone: _____

Your current physical health is □Good □Fair □Poor Currently under physician's care? □Yes □No

Are you allergic to any of the following
(Check all that apply)

____Aspirin	____Erythromycin	____Sedatives
____Codeine	____Jewelry	____Sulfa Drugs
____Latex	____Penicillin	____Tetracycline
____Dental Anesthetics	____Other	

Are you takings any of the following medications?
(Check all that apply)

____Antibiotics	____Aspirin	____Blood Pressure Medications
____Blood Thinners	____Digitalis/Heart Meds	____Insulin/Diabetes Drugs
____Steroids	____Thyroid Medicine	____Tranquilizers/Anti-Depressants

List all your prescription medications:_____

Do you have or have you experienced the following
(Check all that apply)

____Abnormal Bleeding	____Arthritis	____Artificial Bones/Joints
____Artificial Valves	____Asthma	____Cancer
____Chemotherapy/Radiation	____Colitis/Krohn's	____Congenital Heart Defect
____Diabetes	____Difficulty Breathing	____Dry Mouth/Sjorgren's Syndrome
____Emphysema	____Epilepsy/Seizures	____Frequent Headaches
____Heart Attack	____Heart Surgery	____Hepatitis
____High Blood Pressure	____HIV/AIDS	____Kidney Problems
____Liver Disease	____Low Blood Pressure	____Osteoporosis
____Pacemaker	____Rheumatic Fever	____Scarlet Fever
____Sinus Problems	____Stroke	____Thyroid Problems
____Tuberculosis (TB)	____Ulcers	____Sleep Apnea

Medical Conditions not listed above: _____

1. Do you smoke or use tobacco in any form? □ Yes □ No
2. Have you ever taken Bisphosphonate drugs such as Fosamax or Boniva? □ Yes □ No
3. Has it ever been recommended that you take antibiotics prior to a dental visit? □Yes □ No

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Patient Name:_____ _____ _____

Print Name Signature (Parent/Legal Guardian if under 18 yrs of age) Date