In order to provide you with the best possible care, please complete all parts of this form.
***All information is completely confidential.**

MEDICAL HISTORY

Who is your primary care physician? _____ Physician's Phone _____

Physician's Address _____ City _____ State _____ Zip _____

Are you currently under the care of a medical doctor? ..... YES NO
When was your last physical? (Approximate Date) _____
How would you describe your overall health? ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor
Are you having pain or discomfort at this time? ..... YES NO
Do you have dry mouth? ..... YES NO

Please list all medications/drugs you are taking **including regular doses of aspirin, vitamins, herbal or over-the-counter medicines:**

_____

_____

Have you **ever** taken any prescription drugs for weight loss, such as Fen Phen or Redux? ..... YES NO
Have you **ever** taken a bisphosphonate prescription drug for osteoporosis, (i.e., Boniva, Fosamax, Actonel)? ..... YES NO
When you walk up the stairs or take a walk, do you ever have to stop because of a pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
Have you been hospitalized in the last two years? ..... YES NO

If yes, why? _____

Are you **allergic** to, or had an adverse reaction to, any of the following? If so, please **CIRCLE** all that apply:

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Codeine	Erythromycin	Scopolamine	Cephalexin (Keflex)
Darvon	Tetracycline	Percodan	Nebutal/Seconol
Demerol	Penicillin/Amoxicillin	Latex	Other: _____

Please **CIRCLE** any of the following which you have had or currently have:

Acid Reflux Disease	Cold Sores	Hay Fever	Nervousness / Anxiety
A.D.D. or A.D.H.D.	Congenital Heart Problems	Heart Attack	Neurological Disorders
Allergies or Hives	Contact Lenses	Heart Disease	Osteoporosis
Angina Pectoris	Cortisone Medicine	Heart Failure	Psychiatric Care
Arthritis or Gout	Cosmetic Surgery	Heart Pacemaker	Radiation Therapy
Artificial Heart Valve	Crohn's Disease	Heart Surgery	Rheumatism
Artificial Joints (hip, knee, etc...)	Depression	Hemophilia	Sickle Cell Disease
Date Placed: _____	Diabetes	Hepatitis - A B C D E	Sinus Problems
Asthma	Diet (Special/Restricted)	Herpes	Stroke
Bleeding Problems or Anemia	Drug / Alcohol Addiction	High / Low Blood Pressure	Swollen Ankles
Blood Disease	Eating Disorder	HIV / AIDS	Thyroid Problems
Blood Transfusion	Emphysema	Hypoglycemia	Tobacco Use
Bruise Easily	Epilepsy or Seizures	Kidney Disease	Tuberculosis
Cancer (type): _____	Fainting or Dizzy Spells	Liver Disease	Tumor
Chemotherapy	Frequent Thirst	Lung Disease	Ulcers or G.I. Problems
Chest Pain	Frequent Urination	Mitral Valve Prolapse	Venereal Disease
Chronic Cough	Glaucoma		

Do you have, or have you had, any disease, condition or problem not listed? ..... YES NO

If yes, please explain: _____

_____

WOMEN ONLY: Are you pregnant or think you might be pregnant? If yes, how many months? _____ YES NO
Are you currently nursing? ..... YES NO
Are you taking birth control medications? ..... YES NO

WARNING: Use of antibiotics can counteract effectiveness of birth control

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. **I will notify the dentist at each appointment of any changes in my health or medication.**

Patient/Guardian Signature _____ Date _____