Time 5:48 PM

The Dental Team

Date 4/20/2023

MEDICAL HISTORY (created 2023)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, supplements or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Name of your Physician.	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major surgery?	◯ Yes ◯ No	If yes	
Have you had a serious head,neck or jaw injury?	◯ Yes ◯ No	If yes	
Are you taking any medications? Please list any Prescripton natural supplements/vitamins.	◯ Yes ◯ No	If yes	
Have you ever had COVID and/ or been vaccinated against COVID?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications for osteoporosis/bone density?	◯ Yes ◯ No	If yes	
Do you use tobacco products/ medical marijuana/vaping?	◯ Yes ◯ No	If yes	
Do you take blood thinners (Coumadin, Asprin, Plavix, Pradaxa, Eliquis, Fish Oil)?	◯ Yes ◯ No	If yes	
Do you have an artificial joint/implant? Year of surgery, do you need to pre-medicate with antibiotics for dental	◯ Yes ◯ No	If yes	
Have you had open heart surgery, heart valve repalcement or stents?	◯ Yes ◯ No	If yes	
Have you ever had any unusual or serious reactions to epinephrine or local anesthetics?	◯ Yes ◯ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin/Amoxicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Tetracycline	☐ Sulfites		

Do you use controlled substances, medications/ drug or alcohol addiction?	◯ Yes ◯ No	If yes	
Other?	☐	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles/Chicken pox	◯ Yes ◯ No
Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Asthma or COPD	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Environmental allergies	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No
Psychiatric Care	◯ Yes ◯ No	Snore/Sleep Apnea	◯ Yes ◯ No	Delayed Healing	◯ Yes ◯ No	Mononucleosis	◯ Yes ◯ No
Canker Sores/Ulcers	◯ Yes ◯ No	Gallbladder Trouble	◯ Yes ◯ No	Acid Reflux/GERD	◯ Yes ◯ No		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____