Medical Health History

Patient Name: _____ Birthdate: _____/_____/_____ SS#: _____

Address: _____ Zip: _____ Home Phone:_____

Cell Phone: _____ Email _____Employer_____

Employer Phone: _____ Emergency Contact _____ Phone _____

Primary Care Physician: _____ Phone: _____

Have you ever had any of the following conditions: (Check all that apply)

Pacemaker	Artificial or Replacement Valve	Congenital Heart Defect with/without repair
Stent/Shunt	Previous History of Endocarditis	Artificial or Replacement Joints or Pins
Liver Disease	High Blood Pressure	Hepatitis Type A/Type B/Type C (Circle One)
None of the Above		

Are you allergic to or have you ever had an adverse reaction to any of the following: (Check all that apply)

Penicillin	Amoxicillin	Tetracycline	Azithromycin (Z-Pak)
Clindamycin	Cipro	Benzocaine	Adhesive Tape
Codeine	Aspirin	Latex	NSAIDS (Advil. Celebrex)
None of the Above			

Do you currently have or ever had any of the following: (Check all that Apply)

Tuberculosis	Papilloma Virus	Herpes	Autoimmune Disease (RA, Lupus, Sjogren's)
Type I Diabetes	Type II Diabetes	Anemia	Chemotherapy or Radiation Treatments
Asthma	Lung Condition	Canker Sores	Breathing or Respiratory Problems
Heart Disease	Stroke	Cold Sores	HIV
Bleeding Disorder	None of the Above		

YES NO Do you routinely take antibiotic pre-medication prior to dental visits
YES NO Are you allergic to latex?
YES NO Are you currently taking any blood thinners (such as Coumadin)?
YES NO Have you ever noticed that you clench or grind your teeth?
YES NO Do you snore or have sleep apnea?
YES NO Are you pregnant?
YES NO Are you taking birth control pills?
YES NO Do you have any food allergies? If yes, please list: _____
YES NO Do you consume alcohol? If yes, how many drinks per week? _____
YES NO Do you tobacco? If yes, what form: _____ How much? _____
YES NO Have you ever taken bisphosphonate drugs (such as Fosamax)? If so, was it taken: Orally or I.V.
What was the dosage: _____ When did you start: _____ If you stopped, when: _____
YES NO Have you ever had major surgery (organ transplant, open heart surgery, etc.)?
If yes, explain: _____

Do you have any other conditions that our office should be aware of? _____

Please list ***ALL*** medications (including dosage) that you are taking and the reason for taking them: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Patient Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

Revised 1/2/17