

Medical Health History Form

Name _____ Title _____ Name of Spouse _____

Birth Date _____ Gender _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

E-Mail Address _____

Who is your Primary Care Physician? _____ Phone _____

Other Treating Specialist _____ Phone _____

In case of emergency, who should we contact? _____

Have you ever had any of these conditions? Please check all that apply

- Artificial or replacement valve Pacemaker Stent or shunt High blood pressure
- Previous history of endocarditis Liver Disease Artificial or replacement joints or pins
- Congenital heart defect with or without repair Hepatitis Type A Type B Type C
- None of the above**

Do you routinely take antibiotic pre-medication before dental visits? Yes No

Are you allergic to or have you ever had an adverse reaction to any of the following? Please check all that apply

- Penicillin Amoxicillin Tetracycline Azithromycin (z-pack) Clindamycin Cipro
- Benzocaine Adhesive Tape Codeine Nsaids (Advil, Celebrex) Aspirin Latex
- None of the above** Other _____

Please check any of the following that you have or have ever had

- Autoimmune disease (RA, Lupus, Sjogren's) Tuberculosis Papilloma Virus Herpes HIV
- Chemotherapy or radiation treatments Type I Diabetes Type II Diabetes Anemia Asthma
- Breathing or respiratory problems Lung conditions Canker sores Cold sores
- None of the above**

Please answer yes or no to the following:

- 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 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 alcoholic beverages? If yes, how many drinks per week? _____
- Yes No Do you use tobacco? What form and how much? _____
- Yes No Have you ever taken bisphosphonate drugs (such as Fosomax) if so, was it taken (please circle) orally by I.V.
What was the dosage? _____ When did you start _____ If you have stopped, when _____
- Yes No Have you ever had major surgery (organ transplant, open heart surgery, etc.)?
If yes, please explain _____

Do you have any other condition of which our office should be aware? If yes please explain _____

Please list all medications (including dosage) that you are taking along with 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.

Signature _____

Date _____

Dentist's Signature _____

Date _____

MEDICAL HISTORY UPATE

*****FOR OFFICE USE ONLY*****

NO CHANGES

1. Initials: _____ Date: _____

1). Have there been any changes in your Health since your last visit with us? YES NO

2). Are you currently taking any medications? YES NO

If yes please list: _____

3). Do you have any *NEW* allergies or reactions to medications or drugs? YES NO

4). Are there any new diseases/problems/conditions we should know about? YES NO

If yes, please list: _____

5). Have you been hospitalized since your last visit? YES NO

SIGNATURE (*PATIENT*) _____ DATE _____

SIGNATURE (*PROVIDER*) _____ DATE _____

2. Initials: _____ Date: _____

3. Initials: _____ Date: _____

4. Initials: _____ Date: _____

5. Initials: _____ Date: _____

1). Have there been any changes in your Health since your last visit with us? YES NO

2). Are you currently taking any medications? YES NO

If yes please list: _____

3). Do you have any *NEW* allergies or reactions to medications or drugs? YES NO

4). Are there any new diseases/problems/conditions we should know about? YES NO

If yes, please list: _____

5). Have you been hospitalized since your last visit? YES NO

SIGNATURE (*PATIENT*) _____ DATE _____

SIGNATURE (*PROVIDER*) _____ DATE _____

6. Initials: _____ Date: _____

7. Initials: _____ Date: _____

8. Initials: _____ Date: _____

1). Have there been any changes in your Health since your last visit with us? YES NO

2). Are you currently taking any medications? YES NO

If yes please list: _____

3). Do you have any *NEW* allergies or reactions to medications or drugs? YES NO

4). Are there any new diseases/problems/conditions we should know about? YES NO

If yes, please list: _____

5). Have you been hospitalized since your last visit? YES NO

SIGNATURE (*PATIENT*) _____ DATE _____

SIGNATURE (*PROVIDER*) _____ DATE _____

9. Initials: _____ Date: _____

10. Initials: _____ Date: _____