

Medical Health History Form

Legal Name of Patient _____ Birth Date ____/____/____ Gender M / F Title _____
(FIRST) (MI) (LAST)

Name of Spouse _____ E-Mail Address _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Who is your Primary Care Physician? _____ Phone _____

Other Treating Specialist _____ Phone _____

In case of emergency, whom should we contact? _____ Phone _____

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Artificial or replacement valve | <input type="checkbox"/> Congenital heart defect with or without repair |
| <input type="checkbox"/> Stent or shunt | <input type="checkbox"/> Previous history of endocarditis | <input type="checkbox"/> Artificial or replacement joints or pins |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis (<i>circle one</i>) Type A Type B Type C |
| <input type="checkbox"/> 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

- | | | | |
|---|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Azithromycin (z-pack) |
| <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Cipro | <input type="checkbox"/> Benzocaine | <input type="checkbox"/> Adhesive Tape |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex | <input type="checkbox"/> NSAIDS (Advil, Celebrex) |
| <input type="checkbox"/> None of the above | Other _____ | | |

Check any of the following that you currently have or have ever had

- | | | | |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Papilloma Virus | <input type="checkbox"/> Herpes | <input type="checkbox"/> Autoimmune disease (RA, Lupus, Sjogren's) |
| <input type="checkbox"/> Type I Diabetes | <input type="checkbox"/> Type II Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemotherapy or radiation treatments |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung conditions | <input type="checkbox"/> Canker sores | <input type="checkbox"/> Breathing or respiratory problems |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> HIV | | |
| <input type="checkbox"/> None of the above | | | |

Please answer yes or no to the following:

- 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? _____
- Yes No Do you 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 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.

Patient Signature _____ Date _____

Provider Signature _____ Date _____