Medical History Form

Name: DOB:		Today's Date:							
Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental care you will receive.									
Who is/are your phyician(s) currently?									
Have you ever been hospitalized or had a major operation?	Yes	No	If yes:						
Have you ever had a serious head or neck injury?	Yes	No	If yes:						
Are you taking any prescriptions, pills, vitamins, or over-the-counter drugs?	Yes	No	If yes:						
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes:						
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	Yes	No	If yes:						
Are you on a special diet?	Yes	No	If yes:						
Do you use tobacco or vape?	Yes	No	If yes:						
Do you use controlled substances?	Yes	No	If yes:						
Have you have received your COVID-19 vaccination?	Yes	No	If yes:						
*If yes, please list when you have									
received your 1st & 2nd dose?									
Women: Are you?									
Pregnant/Trying to get pregnant?	Yes	No							
Nursing?	Yes	No							
Taking oral contraceptives?	Yes	No							
Are you allergic to any of the following:	?								
Aspirin Yes No			Metal Yes N	o					
Penicillin Yes No	п		Latex Yes N						
Codeine Yes No	ı		Sulfa Drugs Yes N						
Acrylic Yes No			Local Anesthetics Yes N	o					
Other?									

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.

Do you have, or have you had, any of the following? AIDS/HIV Positive Yes No Hemophiliz

AlDrémier Yes No Hemophilia Yes No Alzheimer Yes No Hepatitis A Yes No Anaphylaxis Yes No Hepatitis B or C Yes No Anaphylaxis Yes No Hepatitis B or C Yes No Anaphylaxis Yes No Hepatitis B or C Yes No Anemia Yes No Herpes Yes No Angina Yes No Hearing Loss Yes No Arthritis/Gout Yes No Hearing Loss Yes No Artificial Heart Valve Yes No High Blood Pressure Yes No Artificial Heart Valve Yes No High Cholesterol Yes No Artificial Ident Valve Yes No High Cholesterol Yes No Artificial Joint Yes No High Cholesterol Yes No Ashma Yes No High Cholesterol Yes No Blood Disease Yes No High Cholesterol Yes No Blood Disease Yes No Leukemia Yes No Blood Disease Yes No Leukemia Yes No Brusise Easily Yes No Leukemia Yes No Cancer Yes No Low Blood Pressure Yes No Cancer Yes No Low Blood Pressure Yes No Chemotherapy Yes No Low Blood Pressure Yes No Congenital Heart Disorder Yes No Mitral Valve Prolapse Yes No Congenital Heart Disorder Yes No Parathyroid Disease Yes No Convulsions Yes No Parathyroid Disease Yes No Cortisone Medicine Yes No Radiation Treatments Yes No Dementia Yes No Radiation Treatments Yes No Singles Yes No Singles Yes No Singles Yes No Radiation Treatments Yes No Radiation Treatmen	AIDS/HIV Positive	Yes No	Hemophilia	Yes No
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Excessive Thirst Yes No Sinus Trouble Yes No Fainting Spells/Dizziness Yes No Spina Biffida Yes No Frequent Cough Yes No Stomach/Intestinal Disease Yes No Frequent Diarrhea Yes No Stroke Yes No Frequent Headaches Yes No Swelling of the Limbs Yes No Genital Herpes Yes No Thyroid Disease Yes No Glaucoma Yes No Tonsillitis Yes No Hay Fever Yes No Tuberculosis Yes No Heart Attack/Failure Yes No Tumors or Growths Yes No Heart Murmur Yes No Ulcers Yes No Heart Pacemaker Yes No Venereal Disease Yes No Heart Trouble/Disease Yes No Yellow Jaundice Yes No	Excessive Bleeding	Yes No	Sickle Cell Disease	Yes No
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Heart Trouble/Disease Yes No Yellow Jaundice Yes No			Ulcers	Yes No
Heart Trouble/Disease Yes No Yellow Jaundice Yes No	Heart Pacemaker	Yes No	Venereal Disease	Yes No
Other?	Heart Trouble/Disease	Yes No	Yellow Jaundice	Yes No