MEDICAL HISTORY

PHYSICIAN'S NAME_____PHONE (_____)_____

PHARMACY NAME_____PHONE (_____)_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

~INDICATE WITH A Y FOR YES OR N FOR NO~

_____ AIDS OR HIV
_____ ALLERGIES TO DRUGS
Please list:_____
_____ ANY HEART AILMENTS
Please list:_____
_____ HIGH BLOOD PRESSURE
_____ LOW BLOOD PRESSURE
_____ EXCESSIVE BLEEDING
_____ ANEMIA
_____ BLOOD PROBLEMS
Please list:_____
_____ LATEX ALLERGY

_____ DIABETES
_____ HEPATITIS
_____ KIDNEY DISEASE
_____ ASTHMA
_____ ORGAN TRANSPLANT
Year/Type:_____
_____ CANCER/CHEMO/RADIATION
Year/Type:_____
_____ JOINT REPLACEMENT
Year/Type:_____
_____ SEIZURES
_____ SINUS PROBLEMS

ARE YOU TAKING ANY MEDICATION?_____IF YES, PLEASE LIST_____

HAVE YOU BEEN TOLD BY YOUR DOCTOR THAT YOU NEED TO BE PREMEDICATED WITH ANTIBIOTICS

FOR DENTAL WORK?_____IF YES, FOR WHAT CONDITION?_____

WOMEN, ARE YOU PREGNANT?_____IF YES, WHAT MONTH?_____

HAVE YOU EVER HAD AN ADVERSE REACTION TO DENTAL WORK OR LOCAL ANESTHESIA?_____

HAVE YOU EVER TAKEN BISPHOSPHONATE MEDICATION (BONIVA, FOSAMAX, ZOMETA, ETC)? _____

PLEASE LIST ANY OTHER MEDICAL CONDITIONS OF WHICH YOU FEEL WE SHOULD BE AWARE

_____

WHO SHOULD WE CONTACT IN THE CASE OF AN EMERGENCY?_____

PHONE (_____)_____RELATIONSHIP _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

PATIENT SIGNATURE_____DATE_____
(Parent if a minor)

Thank you for filling out this form completely. It will enable us to help you more effectively.
If you have any questions at any time, please ask us. We are happy to help.