MEDICAL HISTORY FORM

Today's Date: ____________________

Patient's Name ____ Date of Birth ____________________

Please Check ONLY the Box for any condition you have had in the past or have now.

Cardiovascular	Box
Congestive Heart Failure	
Heart Attack/Disease	
Angina or Chest Pain	
Heart Surgery	
High Blood Pressure	
Low Blood Pressure	
Heart Murmur	
Infective Endocarditis	
Congenital Heart Defect/Disease	
Artificial/Prosthetic Heart Valve	
Arrhythmias	
Pacemaker/Defibrillator	
Heart Transplant	
Other Heart Problems	
Blood Thinners	
Aneurysm	
Shortness of Breath	
Swollen Ankles	
Sleep Disorder	
Hematologic	
Blood Transfusion	
Anemia	
Hemophilia	
Leukemia	
Sickle Cell Disease	
Bleeding Tendencies	
Neurologic	
Glaucoma	
Hearing Loss	
Severe Headaches	
Fainting Spells	
Stroke/CVA	
Seizures/Epilepsy	
Psychiatric Treatment	
Paralysis	
Alzheimer's / Dementia	
Gastrointestinal	
Stomach Ulcers	
Gastritis/Colitis	
Hepatitis	
Liver Disease	
Yellow Jaundice	
Cirrhosis	
Eating Disorders	
Diet Suppressants	

Women Only	Box
Currently or Possibly Pregnant	
Currently Breast Feeding	
Use of Oral Contraceptives	
Respiratory	
Hay Fever	
Sinus Trouble	
Allergy/Hives	
Asthma	
COPD	
Emphysema	
Chronic Bronchitis	
Tuberculosis	
Breathing Difficulties	
Dermatologic	
Skin Rash	
Fever Blisters	
Canker Sores	
Endocrine	
Diabetes	
Thyroid Disease	
Steroid Use	
Genitourinary	
Kidney Problems	
Dialysis	
Sexually Transmitted Disease	
Musculoskeletal	
Arthritis	
Osteoporosis	
Joint Replacement	
Bone Disorders	
Muscle Disorders	
Other	
Prostate Problems (Male)	
HIV Positive	
Drug Addiction	
Do you Drink Alcohol	
Tumor or Cancer	
Radiation Treatment	
Chemotherapy	
Organ Transplant	
Tobacco Use	
Unexplained Weight Loss or Gain	
Reaction to General Anesthesia	

ARE YOU ALLERGIC TO:	Box
Local Anesthetics	
Codeine/Narcotics	
Aspirin/NSAIDS	
Barbiturates	
Sedatives	
Sleeping Pills	
Sulfa Drugs	
Iodine	
Metals	
Latex	
Food	
Other	

Are You Allergic to Penicillin, or any Other Antibiotics? ☐ Yes ☐ No

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Any conditions not mentioned here? ________
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Bisphosphonate Derivatives are medications use to strengthen bones and they are used in cancer chemotherapy.

Common Bisphosphonate Derivatives include: Fosamax, Aredia, Actonel, Boniva, Reclast, Zometa, and Didronel.

Are you taking or have you ever taken Bisphosphonate Derivatives ☐ Yes ☐ No

OFFICE USE ONLY

BP ____________________

Pulse ____________________

Med Alert ____________________

PLEASE COMPLETE OTHER SIDE

MEDICAL HX FORM CONT'D.

Today's Date: ______________________

Patient's Name ____

Please Provide the following information about your Primary Care Physician:

Physician's Name ____

Address ____

Phone Number ______________________________ Fax ______________________________

Date of Last Visit ____

2. Have you been hospitalized or had any operations in the past 5 years? Yes___ No___

If yes, please list:

Year **Reason**

____

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3. Are you Currently taking any Prescribed Medications, Herbals or Over-the-Counter drugs? Yes___ No___

If yes, please list:

Current Medication **Dose** **Dentist Medication Notes Only**

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CONSENT TO TREAT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. **It is my responsibility to inform this office of any changes in my health status.** I authorize the dentist to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the dentist to perform any and all forms of dental procedures that may be indicated in connection with my treatment. I also understand the use of local anesthetic agents have the potential for complications including but not limited to infection, allergic reaction, persistent and/or partial numbness, and hematoma.

Signature of patient ____ Date ______________________