MEDICAL HISTORY

Chart # ____________________

Patient Name ____ D.O.B. ____________________________

Address ______________________________________ City ________________________ State ____ ZIP _____________

SSN ___________________________ Phone ______________________ Email _________________________________

Legal Guardian/Caregiver ____ Phone ______________________

Emergency Contact: Name ____ Phone ______________________

Weight _________ Height _________ Gender ☐ Female ☐ Male

Race/Ethnicity: ☐ Hispanic ☐ White ☐ Black/African American ☐ Pacific American ☐ Asian American ☐ American Indian

Preferred Language ____

How did you hear about us? ____

When was your last dental exam _________________________________ Dentist's Name _____________________________

Why have you come to see us today? ____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: ________________________________
Physician's Name: ________________________________
Clinic Name : ________________________________

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: ________________________________

Have you ever been involved in a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: ________________________________

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes, please explain: ________________________________

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: ________________________________

Do you use tobacco? ☐ Yes ☐ No If yes, packs per day: ________________________________

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: ________________________________

Have you received or are you currently receiving any of the following drugs: Fosamax, Actonel, Boniva, Aredia or Zometa? ☐ Yes ☐ No If yes, please explain: ________________________________

Do you reqiure a PreMed? ☐ Yes ☐ No If yes, please explain: ________________________________

Women: Are you… ☐ Pregnant / Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐	Acrylic	☐	Aspirin	☐	Codeine	☐	Latex
☐	Local Anesthetics	☐	Metal	☐	Penicillin	☐	Sulfa Drugs
☐	Tetracycline	☐	Other: ______________________				

Comments: ____

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Do you have, or have you had, any of the following?

☐	**AIDS / HIV Positive**	☐	**Diabetes**	☐	**Organ Transplant**
☐	**Alzheimer's Disease**	☐	**Epilepsy or Seizures**	☐	**Pacemaker**
☐	**Anemia - Chronic**	☐	**Excessive Bleeding**	☐	**Pre-Medication**
☐	**Angina Pectoris**	☐	**Glaucoma**	☐	**Psychiatric Care**
☐	**Antipsychotic Medications**	☐	**Heart Attack / Congestive Heart Failure**	☐	**Radiation / Chemotherapy**
☐	**Arthritis**	☐	**Heart Murmur** ***Only if Pre-Med is required**	☐	**Respiratory Problems**
☐	**Artificial Heart Valve**	☐	**Heart Valve Replacement**	☐	**Rheumatic Fever**
☐	**Artificial Joint**	☐	**Hepatitis**	☐	**Rheumatism**
☐	**Asthma**	☐	**Herpes**	☐	**Shingles**
☐	**Autism**	☐	**High Blood Pressure**	☐	**Spina bifida**
☐	**Cancer**	☐	**Kidney Disease**	☐	**Stomach Problems**
☐	**Chemical Dependency Alcohol / Drugs**	☐	**Leukemia**	☐	**Stroke**
☐	**Congenital Heart Disorder / Defect**	☐	**Liver Disease**	☐	**Thyroid Disease**
☐	**Coagulation Disorder**	☐	**Meniere's Disease (Dizziness)**	☐	**Tuberculosis**
☐	**Coumadin Therapy**	☐	**Mental Disorder**	☐	**Tumors**
☐	**Crohn's Disease**	☐	**Mitral Valve Prolapse**	☐	**Ulcers**
☐	**Depression**	☐	**Nervous Disorder**	☐	**Venereal Disease / STD's**

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: ____

Comments:

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.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN ____ DATE ____________________