PATIENT NAME_____ **DOB** _____ / _____ / _____

MEDICAL HISTORY

What medicine, pills, or supplements are you taking now?

_____

_____

Are you currently under the care of a physician? If so, why?

_____

Physician's Name: _____Date of last physical examination: _____ / _____ /_____

Chief oral complaint: _____

Date of last Dental Exam _____/_____/_____X-rays _____/_____/_____Cleaning_____/_____/_____

DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING CONDITIONS? – INDICATE WITH AN (X)

- Allergic to any drugs or anesthetics – Please List: _____
- Do you now have, or have you been exposed to HIV / AIDS?
- Hepatitis or liver problems?
- Joint replacement (Hip, knee, etc.)? When? _____
- Any heart ailments (Vascular surgery, pacemaker)?
- Mitral valve prolapse / Heart murmur?
- Rheumatic fever?
- Have you ever suffered a stroke?
- Do you have high blood pressure?
- Are you taking a blood thinner (Plavix, Coumadin, Warfarin, Aspirin?
- Excessive bleeding from a cut or dental extraction?
- Have you ever taken Fosamax or Boniva? (How long?) _____
- Do you have anemia or blood problems?
- Tuberculosis?
- Ulcer or colitis?
- Epilepsy?
- Kidney problems?
- Do you have arthritis?
- Diabetes?
- Radiation treatments?
- Malignancies?
- Nervous disorders, fainting, or dizziness?
- Venereal disease?
- Do you have asthma?
- Hay fever or allergies in general?
- Sinus problems?
- Are you pregnant?
- Cigarette pipe or cigar smoking? (How long?) _____
- Teeth sensitive to cold, heat, sweets, or pressure?
- Clenching or grinding of teeth?
- Gums bleed easily?
- Past periodontal treatment?
- Past orthodontic treatment?
- Unfavorable dental experience?

Patient Signature:_____Date: _____ / _____ / _____

To be filled out by Doctor ONLY:
Medical / Dental History Review

Doctor's Signature: _____Date:_____