Medical History Form

Patient Name: Birthdate: Date Created:

MEDICAL SYMPTOMS/GENERAL: In the past 6 months, have you had any of the following?

1. Had pain or tightness in the chest? _____Yes _____No
2. Noticed a change in your vision? _____Yes _____No
3. Had a joint replacement? _____Yes _____No
4. Coughed up blood? _____Yes _____No
5. Had a cough that lasted longer than a few weeks? _____Yes _____No
6. Been exposed to anyone with tuberculosis? _____Yes _____No
7. Found it hard to catch your breath? _____Yes _____No
8. Fainted for no reason? _____Yes _____No
9. Had a heart attack? _____Yes _____No
10. Had a rapid or irregular heartbeat? _____Yes _____No
11. Had migraines or severe headaches? _____Yes _____No
12. Had a stroke or TIA? _____Yes _____No
13. Please write the name and phone number of your physician. _____
    _____
14. Please write the date of your last physical exam. _____
15. Have you ever had a serious illness, operation, or been hospitalized in the past 5 years? If yes, please briefly explain. _____
    _____

ALLERGIES: Are you allergic to or have you had an allergic reaction to any of the following?

Please check any/all that apply:

☐ Aspirin	☐ Augmentin	☐ Erthromycin	☐ Clindamycin
☐ Iodine	☐ Sulfa drugs	☐ Latex	☐ Local anesthetics
☐ Penicillin or Amoxicillin	☐ Metals	☐ Codeine or other narcotics	☐ Barbiturate, sedatives, or sleeping pills
☐ Hay fever or seasonal allergies	If you have an allergy not listed, please briefly explain: _____ _____ _____		_____ _____ _____

1. If you selected an allergy above, please describe your experience. _____
   _____

Medical History Form

DIABETES

1. Do you have diabetes (type 1, type 2, gestational, prediabetic)? _____Yes _____No

If yes, please indicate which one. _____

2. Do you know your last A1C level? _____Yes _____No

If yes, please write what it is. _____

BLOOD THINNERS: Are you taking any BLOOD THINNERS? _____Yes _____No

Please check any/all that apply:

☐ Coumadin	☐ Warfarin	☐ Xarelto (rivaroxaban)	☐ Eloquis
☐ Plavix (clopidogrel)	☐ Heparin	☐ Aspirin	☐ Pradaxa (dabigatran)

1. Are you taking any BLOOD THINNER not listed above? If yes, please write the name of the medication. _____

BISPHOSPHONATES: Have you ever taken, or currently taking, any BISPHOSPHONATE medication? _____Yes _____No

Please check any/all that apply:

☐ Fosamax (alendronate)	☐ Actonel (risedronate)	☐ Boniva (ibandronate)	☐ Reclast (zolendronate)
☐ Prolia (denosumab)	☐ Xgeva (denosumab)	☐ Aredi (pamidronate)	☐ Zometa (zolendronate)

1. Are you taking a BISPHOSPHONATE medication not listed above? If yes, please write what it is. _____
   _____
2. How was/is the BISPHOSPHONATE administered? _____
3. How long are/were you taking the BISPHOSPHONATE? _____
4. When was the last dosage of the BISPHOSPHONATE?_____

Medical History Form

PRESCRIPTION MEDICATIONS:

Are you taking any other prescription medication not listed above? _____Yes _____No

If yes, please write the name(s):

_____

_____

_____

_____

_____

OTHER MEDICATIONS:

Are you taking any over-the-counter medications, supplements, herbs, and/or vitamins?

_____Yes _____No

If yes, please write the name(s):

_____

_____

_____

_____

_____

MEDICAL AND SURGICAL HISTORY

1. **Have you ever had any type (either total or partial) of a joint replacement surgery?** _____Yes _____No

If yes, please check any/all that apply:

☐ Hip	☐ Shoulder	☐ Knee
☐ Finger	☐ Toe	☐ Elbow
☐ Other	Please write the date of the surgery. _____	

Medical History Form

If you answer yes to any of the following questions, please write the date of operation and reason.

1. Have you had a heart valve replacement? _____Yes _____No
   Reason: _____
2. Have you had heart surgery? _____Yes _____No
   Reason: _____
3. Have you had an organ transplant? _____Yes _____No
   Reason: _____
4. Have you had a bone marrow/stem cell transplant? _____Yes _____No
   Reason: _____
5. Has a physician or previous dentist recommended that you take antibiotics before having dental work done? _____Yes _____No
   Reason: _____Name of antibiotic: _____
6. How long are you required to take the pre-medication before dental work is completed? _____

MEDICAL HISTORY SPECIFIC

1. **Do you have a Breathing (Respiratory) Health condition?** __Yes __No

If yes, please select any/all that apply:

☐ Asthma	☐ Bronchitis	☐ Emphysema	☐ Sinus trouble
☐ Tuberculosis	☐ COPD		

2. If you have a Breathing (Respiratory) Health condition not listed above, please briefly explain. _____
   _____

Medical History Form

HEART (CARDIAC) CONDITIONS

1. **Do you have a Heart (Cardiac) Health condition?** _____Yes _____No

If yes, please select any/all that apply:

☐ Pacemaker/ implanted defibrillator	☐ Artificial (prosthetic) heart valve	☐ Previous infective endocarditis	☐ Congenital Heart Disease (CHD)
☐ Heart murmur/ rhythm disorder	☐ Repaired CHD with residual defects	☐ Repaired (completely) CHD in the last 6 months	☐ Unrepaired, cyanotic CHD
☐ Coronary artery disease	☐ Congestive heart failure	☐ Damaged heart valves	☐ Rheumatic heart disease ☐
☐ Ateriosclerosis	☐ Heart attack	☐ Stroke	☐ Afib

2. If you have a Heart (Cardiac) Health condition not listed above, please briefly explain. _____
3. If you selected any condition(s) above, please write the date of diagnosis. _____

CANCER

1. **Do you have, or have you had, a history of cancer?** _____Yes _____No
2. If you selected "yes" to the above question please write the date of diagnosis and type of cancer. _____

If you answered "yes" to the above questions please indicate what type of treatment was completed.

Please select any/all that apply:

☐ Surgery	☐ Radiation	☐ Chemotherapy

3. Please write the date of your cancer treatment: _____

Medical History Form

BLOOD (CIRCULATORY) CONDITIONS

1. **Do you have a Blood (Circulatory) Health condition?** _____Yes _____No

If yes, please select any/all that apply:

☐ Anemia	☐ Hemophilia	☐ High blood pressure	☐ Low blood pressure

2. If you have a Blood (Circulatory) Health condition not listed above, please briefly explain. _____
3. Have you ever had a blood transfusion? _____Yes _____No

If yes, please write date of transfusion and reason: _____

NEUROLOGICAL DISORDERS

1. **Do you have a Brain (Neurological)/Mental Health condition?** ___Yes ___No

If yes, please select any/all that apply:

☐ Traumatic brain injury	☐ Neurological disorder	☐ Mental health disorder	☐ Post-traumatic stress disorder (PTSD)
☐ Anxiety	☐ Concussion	☐ Depression	☐ Epilespy
☐ Alzheimer's/ Dementia			

1. If you have a Brain (Neurological)/Mental Health condition not listed above, please briefly explain. _____

AUTOIMMUNE DISEASES

1. **Do you have an Autoimmune Disease?** _____Yes _____No

If yes, please select any/all that apply:

☐ Rheumatoid Arthritis	☐ Sjogren	☐ Lupus

2. If you have an Autoimmune Disease not listed above, please briefly explain. _____

Medical History Form

DIGESTIVE HEALTH CONDITIONS

1. **Do you have a Digestive Health Condition?** _____Yes _____No

If yes, please select any/all that apply:

☐ Gastrointestinal disease	☐ G.E reflux/persistent heart burn (GERD)	☐ Stomach ulcers

If you have a Digestive Health condition not listed above, please briefly explain.

_____

OTHER CONDITIONS

1. **Do you have any of the following conditions?** _____Yes _____No

If yes, please select any/all that apply:

☐ Arthritis	☐ Chronic pain	☐ Eating disorder	☐ Eye condition
☐ Kidney problems	☐ Immune deficiency	☐ Malnutrition	☐ Thyroid Disease
☐ Hepatitis, jaundice, or liver disease	☐ Sexually transmitted infection	If there is a condition not listed above, please briefly explain:	_____ _____ _____ _____

TOBACCO/NICOTINE

1. **Do you use any form of TOBACCO or NICOTINE products?** _____Yes _____No

If yes, please select any/all that apply:

☐ Cigarettes	☐ Cigars	☐ Snuff	☐ Chew	☐ Bidis
☐ Vaping products				

2. Do you use any CONTROLLED SUBSTANCES (drugs), including marijuana, for medicinal or reactional reasons? _____Yes _____No

If you answered yes to the previous question, please briefly explain: _____

_____

Medical History Form

WOMEN ONLY

1. Are you currently taking any birth control pills? _____Yes _____No
2. Are you pregnant? _____Yes _____No How many weeks? _____
3. Are you currently nursing? _____Yes _____No

ADDITIONAL COMMENTS:

➡**NOTE: It is important for both the doctor and the patient to talk honestly about the patient's health before dental treatment starts.**

I have answered the above questions completely, accurately, and to the best of my ability.

Patient's Signature:

X _____Date:_____

FOR COMPLETION BY PROVIDER

Doctor comment: _____

Office use only:

☐ Medical alert	☐ Premedication	☐ Allergies	☐ Anesthetics	☐ Nitrous Oxide

Reviewed by: _____

Date: _____