■ Medical History ■

Patient Name:_____**Date of Birth:**_____**Today's Date:**_____

Physician's Name:_____ Physician's Phone:_____Date of Last Physical:_____

In Case of Emergency, Notify _____ Phone:_____Relationship_____

List **ALL MEDICATIONS** currently taking (including supplements):_____

_____

_____

Have you ever had any kind of surgery? ☐Yes ☐No

If yes, When?_____ For What?_____

_____

Do you have a Prosthetic Heart Valve or Joint Replacement/Pins (i.e. Hip, Knee, Ankle, etc)? ☐Yes ☐No
Date:_____Describe:_____

Have you been told you need ***Pre-Medication*** prior to dental treatment? ☐Yes ☐No If yes, Why?_____

_____

Have you ever had any trouble with ***Prolonged Bleeding*** after surgery? ☐Yes ☐No
Are You Taking Blood Thinners**:** ☐Baby Asprin ☐Asprin ☐Plavix ☐Coumadin ☐Pradaxa Other:_____

Have you ever taken ***Bisphosphonates*** (Fosamax, Boniva, Actonel, Zometa, Aredia etc)? ☐Yes ☐No Other:_____

Do You Have Any Allergies**:** ☐Latex ☐Metals ☐Penicillin ☐Anesthetics Other:_____

Women: Birth Control Medication ☐Yes ☐No ☐ Pregnant: # Weeks_____ Are you Nursing? ☐Yes ☐No

■ CONDITIONS *(check all that apply)* ■

Y/N	Y/N	Y/N	Y/N
☐☐Anemia	☐☐Diabetes	☐☐Heart Attack	☐☐Liver Disease
☐☐Abnormal Bleeding	☐☐Difficulty Breathing	☐☐Heart Disease	☐☐Low Blood Pressure
☐☐Angina	☐☐Drug Addiction	☐☐Heart Surgery	☐☐Pacemaker
☐☐Arthritis	☐☐Emphysema	☐☐Hemophilia	☐☐Rheumatic Fever
☐☐Asthma	☐☐Epilepsy	☐☐Hepatitis A, B or C	☐☐Seizures
☐☐Autism Spectrum Disorder	☐☐Fainting/Dizzy Spells	☐☐High Blood Pressure	☐☐Severe Headaches
☐☐Autoimmune Disease	☐☐Fever Blisters	☐☐HPV	☐☐Stroke
☐☐Cancer	☐☐GI Disease/Reflux	☐☐Infective Endocarditis	☐☐Thyroid Disease
☐☐Congestive Heart Failure	☐☐Herpes	☐☐Kidney Problems	
☐☐Congenital Heart Defect	☐☐HIV+ AIDS		

Any other information we should know about your health?:_____

_____

_____

■ Dental History ■

Y/N	Y/N	Y/N	Y/N
☐☐ Sensitive Teeth	☐☐ Jaw Pain (TMJ)	☐☐ Bleeding Gums	☐☐ Bad Breath
☐☐ Discolored Teeth	☐☐ Clenching/Grinding	☐☐ Periodontal Disease	☐☐ Tobacco Use
☐☐ Dry Mouth	☐☐ Cracked Teeth	☐☐ Tooth Trauma	

Other Dental Conditions not mentioned above:_____

_____

I understand the information I have provided is correct to the best of my knowledge. I 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.

Signature: _____ **Date:** _____