Medical Health History Form

Name ____ Title _______ Name of Spouse _________________________________

Birth Date ___________ Gender ____ Home Phone _________________Work Phone _______________ Cell Phone ______________

Address ____ City __________________ State ______ Zip _____________

E-Mail Address____

Who is your Primary Care Physician? ____ Phone _______________________________

Other Treating Specialist____ Phone_______________________________________

In case of emergency, who should we contact?____

Have you ever had any of these conditions? Please check all that apply

❑ Artificial or replacement valve ❑Pacemaker ❑Stent or shunt ❑High blood pressure
❑ Previous history of endocarditis ❑Liver Disease ❑Artificial or replacement joints or pins
❑ Congenital heart defect with or without repair ❑Hepatitis ❑Type A ❑Type B ❑Type C

❑ None of the above

Do you routinely take antibiotic pre-medication before dental visits? Yes No

Are you allergic to or have you ever had an adverse reaction to any of the following? Please check all that apply

❑ Penicillin ❑ Amoxicillin ❑ Tetracycline ❑ Azithyromycin (z-pack) ❑ Clindamycin ❑ Cipro
❑ Benzocaine ❑ Adhesive Tape ❑ Codeine ❑ Nsaids (Advil, Celebrex) ❑ Aspirin ❑ Latex

❑ None of the above Other____

Please check any of the following that you have or have ever had

❑Autoimmune disease (RA, Lupus, Sjogren's) ❑ Tuberculosis ❑ Papilloma Virus ❑ Herpes ❑ HIV
❑Chemotherapy or radiation treatments ❑ Type I Diabetes ❑ Type II Diabetes ❑ Anemia ❑ Asthma
❑Breathing or respiratory problems ❑ Lung conditions ❑ Canker sores ❑ Cold sores

❑ None of the above

Please answer yes or no to the following:

Yes No Are you allergic to latex?
Yes No Are you currently taking any blood thinners (such as Coumadin)?
Yes No Have you ever noticed that you clench or grind your teeth?
Yes No Are you pregnant?
Yes No Are you taking birth control pills?
Yes No Do you have any food allergies? If yes, please list____
Yes No Do you consume alcoholic beverages? If yes, how many drinks per week? ____________________________________
Yes No Do you use tobacco? What form and how much? ____
Yes No Have you ever taken bisphosphonate drugs (such as Fosomax) if so, was it taken (please circle) orally by I.V.
What was the dosage? ____________ When did you start ____________ If you have stopped, when _____________
Yes No Have you ever had major surgery (organ transplant, open heart surgery, etc.)?
If yes, please explain____

Do you have any other condition of which our office should be aware? If yes please explain

____

Please list all medications (including dosage) that you are taking along with the reason for taking them _______________________

____

____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature ____ Date ______________________

Dentist's Signature ____ Date ______________________

MEDICAL HISTORY UPATE

***************FOR OFFICE USE ONLY***************

NO CHANGES

1. Initials: ________ Date: _______
2. Initials: ________ Date: _______
3. Initials: ________ Date: _______
4. Initials: ________ Date: _______
5. Initials: ________ Date: _______
6. Initials: ________ Date: _______
7. Initials: ________ Date: _______
8. Initials: ________ Date: _______
9. Initials: ________ Date: _______
10. Initials: ________ Date: _______

1). Have there been any changes in your Health since your last visit with us? YES NO

2). Are you currently taking any medications? YES NO

If yes please list: ____

3). Do you have any *NEW* allergies or reactions to medications or drugs? YES NO

4). Are there any new diseases/problems/conditions we should know about? YES NO

If yes, please list: ____

5). Have you been hospitalized since your last visit? YES NO

SIGNATURE (*PATIENT*) ___________________________________ DATE_________

SIGNATURE (*PROVIDER*) _________________________________ DATE__________

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2). Are you currently taking any medications? YES NO

If yes please list: ____

3). Do you have any *NEW* allergies or reactions to medications or drugs? YES NO

4). Are there any new diseases/problems/conditions we should know about? YES NO

If yes, please list: ____

5). Have you been hospitalized since your last visit? YES NO

SIGNATURE (*PATIENT*) ___________________________________ DATE_________

SIGNATURE (*PROVIDER*) _________________________________ DATE__________

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2). Are you currently taking any medications? YES NO

If yes please list: ____

3). Do you have any *NEW* allergies or reactions to medications or drugs? YES NO

4). Are there any new diseases/problems/conditions we should know about? YES NO

If yes, please list: ____

5). Have you been hospitalized since your last visit? YES NO

SIGNATURE (*PATIENT*) ___________________________________ DATE_________

SIGNATURE (*PROVIDER*) _________________________________ DATE__________