Medical Health History Form

Legal Name of Patient _____ Birth Date _____/_____/_____ Title _____
(FIRST) (MI) (LAST)

Gender Identity: M/F/Other (please specify): _____ Pronouns: He, Him, His / She, Her, Hers / They, Them, Theirs

Name of Spouse _____ E-Mail Address _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Who is your Primary Care Physician? _____ Phone _____

Other Treating Specialist _____ Phone _____

In case of emergency, whom should we contact? _____ Phone _____

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

- ❑ Pacemaker
- ❑ Artificial or replacement valve
- ❑ Congenital heart defect with or without repair
- ❑ Stent or shunt
- ❑ Previous history of endocarditis
- ❑ Artificial or replacement joints or pins
- ❑ Liver Disease
- ❑ High blood pressure
- ❑ Hepatitis *(circle one)* Type A Type B Type C
- ❑ **None of the above**

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

- ❑ Penicillin
- ❑ Amoxicillin
- ❑ Tetracycline
- ❑ Azithyromycin (z-pack)
- ❑ Clindamycin
- ❑ Cipro
- ❑ Benzocaine
- ❑ Adhesive Tape
- ❑ Codeine
- ❑ Aspirin
- ❑ Latex
- ❑ NSAIDS (Advil, Celebrex)
- ❑ **None of the above**

Other_____

Check any of the following that you currently have or have ever had

- ❑ Tuberculosis
- ❑ Papilloma Virus
- ❑ Herpes
- ❑ Autoimmune disease (RA, Lupus, Sjogren's)
- ❑ Type I Diabetes
- ❑ Type II Diabetes
- ❑ Anemia
- ❑ Chemotherapy or radiation treatments
- ❑ Asthma
- ❑ Lung conditions
- ❑ Canker sores
- ❑ Breathing or respiratory problems
- ❑ Cold sores
- ❑ HIV
- ❑ **None of the above**

Please answer yes or no to the following:

Yes No Do you routinely take antibiotic pre-medication prior to dental visits?
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 Do you snore?
Yes No Do you have sleep apnea?
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.

Patient Signature _____ Date _____

Provider Signature _____ Date _____