Medical History

Name:_____Date of Birth:_____Gender: M / F Weight_____

Primary Care Physician_____Date of last visit_____

Physician's Address_____Phone #_____

Are you under the care of a specialist? Yes No Type_____

Specialist name_____Phone #_____

Address_____City_____State/Zip_____

Women: Are you pregnant? Yes No What month?_____ Nursing? Yes No

Taking Birth Control Pills? Yes No Hormone Replacement Therapy? Yes No

Please check any of the following that you have now or have experienced in the past:

- □ Acid Reflux/GERD
- ❑ Addiction: *Type*
- □ Alcohol Use:
  How often:
- □ Allergies (list on next page)
- □ Anemia
- □ Arthritis/Rheumatism
- □ Artificial Heart Valves
- □ Artificial Joints:
  Type:
  Date:
- □ Asthma
- □ Back Problems
- □ Bisphosphonate Therapy
  i.e. Fosomax, Actonel, etc
  Which:
- □ Blood/Bleeding Disorders
  Describe:
- □ Blood Transfusion
  Date:
- □ Cancer: *Type*
- □ Chemotherapy
  Date Completed:
- □ Circulatory Problems
- □ Cortisone Treatment
- □ Cough, Persistent
- □ Cough up blood
- □ Diabetes: *Type*
- □ Eating Disorder
  Specify:
- □ Epilepsy
- □ Fainting
- ❑ Fibromyalgia
- □ Gastrointestinal Surgery
  i.e. Bypass, LapBand
- □ Glaucoma
- □ Headaches
- □ Heart murmur
- □ Heart Problems
  Describe:
- □ Hepatitis: *Which:*
  - □ Exposure to Hepatitis
- □ Herpes Virus/Cold Sores
- ❑ High Blood Pressure
- □ High Cholesterol
- □ HIV Positive/AIDS
- □ Exposure to HIV/AIDS
- □ Kidney Problems
- □ Latex Allergy
- □ Liver Problems
- □ Mitral Valve Prolapse
- □ Nervous System Problems
- □ Osteoporosis
- ❑ Opiate Therapy
- □ Pacemaker: *Date:*
- □ Psychiatric Care
- □ Radiation Therapy
  Date Completed:
  Site:
- □ Respiratory Problems
  Describe:
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Sexually Transmitted Disease
- □ Shortness of Breath
- □ Sinus Trouble
- □ Skin Rash
- □ Skin Reaction to Metals
  Describe:
- □ Sleep Apnea
- □ Steroid Use
  Describe:
- □ Stroke
- □ Swelling of Feet or Ankles
- □ Thyroid Problems:
  Hypo or Hyper
- □ Tobacco Use
  Type:
  How often:
- □ Tonsillitis
- □ Tonsils Removed
- □ Tuberculosis
- □ Ulcer
- □ Other:

Does anyone in your immediate family have a history of any the above listed conditions?

Please describe:_____

Medications

Are you taking or have you recently taken any medicine(s) including over---the---counter, non---prescription and herbal medications? Yes No If **yes**, list below:

Herbal Medications: check box or other:_____

Aloe ☐	Coenzyme10 ☐	Echinacea ☐	Ephedra ☐
Garlic ☐	Gingko Biloba ☐	Ginseng ☐	Goldenseal ☐
Hawthorne ☐	Kava---Kava ☐	Melatonin ☐	Licorice Root ☐
Saw Palmetto ☐	St John's Wort ☐	Valerian ☐	Yohimbe ☐

Prescription and Non-Prescription Medications: **None** ☐

Medical Condition	Medication	Dosage

Allergies: If NONE, check HERE ☐

Drug Allergies:_____

Other Allergies:_____

I certify that the above information is accurate and correct. I understand that providing incorrect or incomplete health information can be dangerous and compromise my dental treatment. I also understand that this information will be held in the strictest of confidence and will only be released to relevant health professionals as needed to treatment. It is my responsibility to update my medical information as changes occur in the future.

Signature_____Date_____

Medical History Update

I have reviewed the above information and have updated it as needed.

Date	Patient's Initials	Clinician's Initials	Date	Patient's Initials	Clinician's Initials