Medical History

Patient Name		Birth Date

Are you under a physician's care now?	Physician's Name	Physician's Phone Number
◯ Yes ◯ No		

Explain Physician Care Plan

Have you had any hospitalizations or major operations?	Please Explain
◯ Yes ◯ No	

Do you consume tobacco or tobacco products?	Tobacco Type(s)	How Often?
◯ Yes ◯ No		

Are you currently taking any pills or medications?	Please List All Medication
◯ Yes ◯ No	

Are you allergic to any of the following medication? (Check All That Apply)

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Local Anesthetics

Please explain any other allergies that you may have

Do you have, or have you had, any of the following?

☐ AIDS/HIV	☐ Epilepsy/Seizures	☐ Mitral Valve Prolapse
☐ Anemia	☐ Fainting/Dizziness	☐ Psychiatric Care
☐ Arthritis/Gout	☐ Headaches	☐ Pregnant/nursing
☐ Artificial Heart Valve	☐ Hay Fever	☐ Radiation Treatments
	☐ Asthma	☐ Rheumatic Fever

- [ ] Artificial Joint Replacement
- [ ] Heart Murmur
- [ ] Heart Pace Maker
- [ ] Any Artificial Objects in Body
- [ ] Pre-Medicated
- [ ] Birth Control
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Blood Thinners
- [ ] Breathing Problem
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Chest Pain
- [ ] Congenital Heart Disorder
- [ ] Scarlet Fever
- [ ] Heart Disease
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] High Blood Pressure
- [ ] Hypoglycemia
- [ ] Irregular Heartbeat
- [ ] Kidney Problems
- [ ] Leukemia
- [ ] Liver Disease
- [ ] Lung Disease
- [ ] Emphysema
- [ ] Heart Attack
- [ ] Sickle Cell Disease
- [ ] Sinus Trouble
- [ ] Stomach/Intestinal issue
- [ ] Stroke
- [ ] Thyroid Disease
- [ ] Tuberculosis
- [ ] Tumors/Growths
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Drug Addiction
- [ ] Diabetes

Do you have any other serious illnesses or conditions not listed above? If so, please explain further.

Comments / Notes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Name

Patient (or Guardian/Parent) Signature

Date

Clear Form **Print Form**