Medical History

In the event of an emergency is there someone who lives near you we should contact?

Their Name: _____

Relationship:_____

Wk#:_____

HM/Cell#:_____

Do you have a personal physician? ✿✿✿✿ Yes ✿✿✿✿ ✯✯

Physician's name:_____

Date of last visit: _____

Are you currently under the care of a physician? ✿✿✿✿ Yes ____ No

Please explain: _____

Do you require antibiotics before dental work? ✿✿✿✿ Yes ✿✿✿✿ No

Have you ever been treated for osteoporosis or bone cancer? ✿✿✿✿ Yes ____ No

Are you taking any prescription or over the counter drugs? ✿✿✿✿ Yes ✿✿✿✿ No

\Please list each one:

_____

_____

Please list any allergies:

_____

_____

Please circle if you have or have had the following:

Y N Abnormal Bleeding
Y N Anemia
Y N Artificial Joints- when placed? _ _____
Y N Asthma
Y N Colitis
Y N Congenital Heart Defect- corrected? _____
Y N Drug Abuse
Y N Emphysema
Y N Fainting Spells
Y N Glaucoma
Y N Heart Attack- when? _____
Y N Heart Murmur (Rheumatic Fever/Scarlet Fever)

Y N Alcohol Abuse
Y N Arthritis
Y N Artificial Heart Valves
Y N Cancer/Chemotherapy/Radiation
Y N Diabetes
Y N Difficulty breathing
Y N Eating Disorder
Y N Epilepsy/Seizures
Y N Frequent Headaches
Y N Hemophilia
Y N High Blood Pressure
Y N High Cholesterol

Y N Heart Surgery- when? _____
Y N Hepatitis Type? _____
Y N HIV / AIDS
Y N Kidney Problems

Please circle if you have or have had the following:

Y N Liver Disease
Y N Pacemaker- when? _____
Y N Pregnant/Nursing
Y N Sickle Cell Disease/Traits
Y N Steroid Therapy
Y N Low Blood Pressure
Y N Persistent Cough
Y N Psychiatric Problems
Y N Sinus Problems
Y N Thyroid Problems
Y N Autoimmune Disease (MS, Lupus, RheumatoidArthritis, Sjogrens, etc)
Y N Stroke- when? _ _____
Y N Tobacco use - interested in quitting? ✿✿✿✿Yes ____ No
Y N Tuberculosis (TB) - when? _____
Y N Ulcers

Please list any serious medical condition(s) that you have experienced:

_____

I understand that the health information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform any necessary dental services that I may need with my informed consent during diagnosis and treatment.

_____ _____/_____/ 20_____

Signature Date

Update:

Intitial: _____Date: _____

Intitial: _____Date: _____

Intitial: _____Date: _____

Intitial: _____Date: _____