MEDICAL HISTORY FORM

Name _____Spouse (or parents if under 18) _____

Address_____Birthdate_____

Home phone _____ Cell phone _____e-mail_____

Employer_____Work phone_____Number of children in family_____

Medical Doctor _____ Phone _____ Date last seen _____

Previous dentist /date last seen_____ Reason here today_____

Whom may we thank for referring you to our office? Name _____

LIST CURRENT MEDICATIONS (Prescription, Over the counter and Herbal)

MEDICATION	DOSAGE	FREQUENCY		MEDICATION	DOSAGE	FREQUENCY

Check if you have any of the conditions listed below

	Yes
Allergy to penicillin	
Allergy to latex	
Major surgery in past 3 years	
Any other serious allergies	
Diabetes	
High blood pressure	
Artificial knee, hip or other joint	
Artificial heart valve	
Hemophilia /excessive bleeding	
Asthma	
Osteoporosis	
Cancer	
Heart bypass	
Heart pacemaker or defibrillator	
Other heart disease	
Arthritis	
Stroke	
Pregnant	
On birth control pills	
AIDS or HIV infection	

IF NO KNOWN HEALTH PROBLEMS CHECK HERE ➡	
	Yes
Blood thinners (Coumadin, Plavix)	
Tuberculosis	
Frequent headaches	
Reaction/rash due to any metals	
Seasonal allergies	
Ever received chemotherapy	
Radiation therapy to jaw area	
Kidney or liver (Hepatitis) disease	
Glaucoma	
Mental illness or depression	
Anorexia or bulimia	
Epilepsy (seizures)	
Addiction to any drugs	
Smoking or chewing tobacco	
Grind or clench your teeth	
Sinus problems	
Snoring or sleep apnea	
Soda or flavored drinks daily	
Anything not listed above	

Signature (Parent or legal guardian if under 18)

_____**Date**_____

Medical History Update (Initial and Date)

1_____ **2**_____ **3**_____ **4**_____ **5**_____

6_____ **7**_____ **8**_____ **9**_____ **10**_____