MEDICAL HISTORY

Patient Name:_____ **Date of Birth:**_____

Please Circle YES or NO to indicate if you have had any of the following:

Anemia	Yes No	Diabetes: Type I Type II	Yes No	Sickle Cell Disease	Yes No
Arthritis	Yes No	Insulin Dependent	Yes No	Sinus Trouble	Yes No
Asthma	Yes No	Dry Mouth	Yes No	Skin Condition	Yes No
Auto Immune Disorder	Yes No	Epilepsy or Seizures	Yes No	Sleep Apnea	Yes No
Back Problems	Yes No	Fainting/ Dizziness	Yes No	Special Diet	Yes No
Blood Pressure-HIGH	Yes No	Headaches/Migraines	Yes No	Stroke	Yes No
LOW	Yes No	Heart Problems_____	Yes No	Tobacco	Yes No
Cancer- Radiation	Yes No	HIV+ or AIDS	Yes No	Thyroid	Yes No
Chemotherapy	Yes No	Jaundice	Yes No	Tuberculosis	Yes No
Surgery	Yes No	Kidney Disease-Stage___	Yes No	Tumors/Growth	Yes No
Chemical Dependency	Yes No	Liver Disease	Yes No		
Circulatory Problems	Yes No	Musculoskeletal Disease	Yes No	Date of last A1C_____	
Clotting/Bleeding Disorder	Yes No	Osteoporosis	Yes No	Blood Sugar Range_____	
Contacts	Yes No	Psychiatric Care	Yes No	Usual Blood Pressure_____	
Cortisone Treatments	Yes No	Respiratory Disease	Yes No	***OTHER:** List ANY condition not listed	
Cough, Persistent or Bloody	Yes No	Sexually Transmitted Disease	Yes No	_____	
Developmental Disorder	Yes No	Type_____		_____	
Type_____		Shortness of Breath	Yes No	_____	

_____

Have you ever had any complications following **dental treatment?** YES NO If yes, please describe_____

_____.

Have you ever had a reaction to **Local Anesthetic?** YES NO If yes, please describe_____

_____.

Have you ever been hospitalized or do you have **ANY OTHER HEALTH CONCERNS?** YES NO If yes, please describe_____

_____.

Have You Ever:

Taken any of these MEDICATIONS:		**Been DIAGNOSED with:**		**Had an ALLERGIC REACTION to:**	
Blood Thinners	Y N	Angina Pectoris	Y N	Aspirin	Y N
Bone Building-Biophosphonates	Y N	Artificial Heart Valves	Y N	Barbiturates	Y N
Coumadin	Y N	Artificial Joint,Screws,Pins	Y N	Codeine	Y N
Dexfenfluramine	Y N	Congenital Heart Defect	Y N	Ibuprofen	Y N
Diet Medications	Y N	Heart Murmur	Y N	Latex	Y N
Fen-phen	Y N	Mitral Valve Prolapse	Y N	Local Anesthesia	Y N
Levoxyl	Y N	Organ Transplant	Y N	Metals(gold,nickel,etc.)	Y N
Pondimin	Y N	Pacemaker	Y N	Penicillin	Y N
Redux	Y N	Rheumatic Fever	Y N	Sulfa	Y N
Other_____		Stint_____	Y N	Other_____	

Women: Are you Pregnant? Y N	**Emergency Contact Information:**	**How did you find us?**
Due Date_____	Name_____	☐ Facebook
Are you Nursing? Y N	Relationship_____	☐ Google Review
Taking Birth Control Pills? Y N	Phone_____	☐ Website
		☐ Referred by Friend/Patient
		Name_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child, have a change in health, medications, surgeries, or hospitalizations.

Patient/Guardian_____**Relationship**_____ **Date**_____

1ST Update_____ **Date**_____

2nd Update_____ **Date**_____

3rd Update_____ **Date**_____

RX LOG

PATIENT NAME_____ DOB_____

Physician Name: _____ Physician Phone: _____

Pharmacy: _____ Pharmacy Phone: _____

MEDICATION	DOSAGE	INITIALS	DATE