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Medical History Form

Patient Name_____ **Date** _____

Please check if you currently have or have had any of the following problems:

☐ AIDS/HIV Positive	☐ Diabetes	☐ Mood Disorders
☐ Anemia	☐ Epilepsy	☐ Pacemaker
☐ Arthritis	☐ Fainting	☐ Nervous Problems
☐ Artificial Heart Valves	☐ Glaucoma	☐ Radiation Treatment (dates) _____
☐ Artificial joints	☐ Headaches, frequent	☐ Respiratory disease
☐ Asthma	☐ Heart murmur	☐ Rheumatic fever
☐ Blood disease	☐ Heart Problems	☐ Seizure disorders
☐ Blood Thinners _____	☐ Herpes	☐ Shortness of breath
Coumadin/Warfarin/Aspirin	☐ Hepatitis A B C	☐ Stroke
☐ Cancer (type) _____	☐ High blood pressure	☐ Surgical Implants
☐ Chemotherapy	☐ Jaw problems	☐ Thyroid problems
☐ Circulation problems	☐ Kidney disease	☐ Tuberculosis
☐ Cortisone treatments	☐ Liver disease	☐ Ulcers/colitis

Women: ☐ pregnant ☐ Breast feeding

Do you drink? How much_____

Do you smoke? How much_____

Do you use Tobacco? (smoke or smokeless) How much_____

Known Allergies: (including food- and type of reaction)

_____
_____
_____
_____

List any medications you are currently taking:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Primary Care Physician: _____ **General Dentist:** _____

Preferred Pharmacy: _____

List of most recent and major surgeries:

_____
_____
_____

Authorization:

I have reviewed the information and answered all questions to the best of my knowledge. I understand this information will be used to determine the dental treatment I receive at this office and may be shared with other medical offices only as necessary. I will notify the office should any information change in the future.

Signature of patient, or parent/guardian if a minor: _____

Reviewed by:_____ Date Signed: _____