## MEDICAL HISTORY

| NAME: | DOB: |
|---|---|

**Please check ALL of the following conditions that you presently have or have had in the past**

___ Heart: attack, surgery
Date:____________
___ Heart: pacemaker
Date:____________
___ Heart: stent Date:____________
___ Heart: artificial heart valve
Date:____________
___ Heart: CHF, AFIB, Arrythmia,
Date:____________
___ Stroke, TIA Date:____________
___ Mitral Valve Prolapse, Murmur
___ Angina
___ High Blood Pressure
___ Low Blood Pressure
___ High Cholesterol

___ Diabetes: Type____________
___ Circulatory problems
___ Respiratory Issues: COPD, emphysema

___ Asthma, shortness of breath
___ Seizures: Type:_______________
Date of last episode:____________
___ Neurological Disorders; Parkinson's

___ Cancer: Type:______________
Date:____________
___ Radiation treatment
___ Chemotherapy
___ Dry mouth

___ Artificial joint: hip, knee, other____________ Date:_________
___ Bleeding/ clotting problems
___ Acid reflux, GERD
___ Thyroid issues: hyper, hypo
___ Arthritis: Type:____________
___ Sjogren's syndrome
___ Anxiety ___ Depression

___ Kidney disease
___ Liver disease
___ Hepatitis: Type:____________
Date:____________
___ Tuberculosis: Date:____________
___ AIDS/HIV: Date:____________
___ Osteoporosis
___ Bisphosphonate medication
___ Mouth sores: herpes, canker sores
___ Sleep apnea: device ______________
___ Snoring
___ Vertigo
___ Fainting
___ Memory loss ___ Hearing loss
___ Jaw pain
___ Headaches
___ Mental health: describe ___________
___ Tobacco use
___ Drug/Alcohol dependency
___ Pregnancy: Due Date:____________

**YES NO** Do you have any allergies or adverse reactions? **LATEX PENICILLIN GLUTEN SULFA CODEINE OTHER** _________________________

**YES NO** Do you take antibiotic premedication prior to your dental visits? Reason_____________________________ Years to be taken ________

**List all medications you are currently taking: Or attach a copy of your medication list**

Drug _________________________ Reason_______________________ Drug _________________________ Reason_______________________

Drug _________________________ Reason_______________________ Drug _________________________ Reason_______________________

Drug _________________________ Reason_______________________ Drug _________________________ Reason_______________________

**YES NO** Do you have any conditions not listed **OR** any important information to share? ______________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

**PATIENT/GUARDIAN SIGNATURE**____________________________________________________ **DATE**______________________________

**UPDATES**

Date _______ Changes ______________________________________________________________________________

Patient Signature ________________________________________________________________ Staff _________________

Date _______ Changes ______________________________________________________________________________

Patient Signature ________________________________________________________________ Staff _________________

Date _______ Changes ______________________________________________________________________________

Patient Signature ________________________________________________________________ Staff _________________