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 ___ Vape Pen
___ Drug/Alcohol dependency
___ Currently Pregnant: Due:_____
___ Gender Identity: Pronouns: _____

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_____

Do you have any conditions not listed **OR** any important information to share? _____

_____

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

UPDATES: Please review the above medical history. If there are any changes, add the changes below. If no changes, please write 'none'.

Date _____ Changes _____
Patient Signature _____ Staff _____
Date _____ Changes _____
Patient Signature _____ Staff _____
Date _____ Changes _____
Patient Signature _____ Staff _____