Medical History

Patient Name (print): _____

Please mark (x) any of the following conditions that apply to you:

Cancer
Type: _____
_____
☐ Chemotherapy
☐ Radiation therapy

Cardiovascular disease
☐ Angina (chest pain)
☐ Artificial heart valve
☐ Heart conditions
☐ Heart surgery
☐ High/low blood pressure
☐ Mitral valve prolapse
☐ Pacemaker
☐ Rheumatic Fever
☐ Scarlet fever
☐ Stroke

Endocrinology
☐ Diabetes
☐ Hepatitis A/B/C
☐ Jaundice
☐ Kidney disease
☐ Liver disease
☐ Thyroid disease

Gastrointestinal
☐ Ulcers (stomach)
☐ Gastrointestinal disease

Hematologic/Lymphatic
☐ Anemia
☐ Blood disorders
☐ Bruise easily
☐ Excessive bleeding

Musculoskeletal
☐ Arthritis
☐ Artificial joints
☐ Jaw joint (TMJ) pain
☐ Rheumatoid arthritis

Neurological
☐ Anxiety
☐ Depression
☐ Dizziness
☐ Drug/alcohol addiction
☐ Fainting
☐ Seizures
☐ Psychiatric illness

Respiratory
☐ Asthma
☐ Emphysema
☐ Respiratory problems
☐ Sinus problems
☐ Sleep apnea
☐ Tuberculosis

Viral Infections
☐ AIDS
☐ HIV positive
☐ HPV

Women
☐ Currently pregnant
☐ Nursing

Medical Allergies
☐ Antibiotics (Penicillin/Amoxicillin/Clindamycin) ☐ Opioids (Percocet, Oxycodone, Tylenol 3)
☐ Latex ☐ Local Anesthetics ☐ NSAIDs
☐ Other: _____
Additional Comments: _____

Are you under the care of a physician ☐ Y ☐ N
If yes, explain: _____
Physician Name: _____ Address: _____ Phone: _____

Have you had a serious illness, operation, or hospitalization in the past 5 years? ☐ Y ☐ N
If yes, explain: _____
_____
Have you ever in the past, or are you now currently taking any medication for osteopenia/osteoporosis or bone disease?
☐ Y ☐ N If yes, please list: _____

Medications

Prescription/Dosage:	Condition:	OTC/Supplement/Vitamins:	Condition:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Consent:
The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

_____ _____ _____ _____
Signature of Patient/Legal Guardian *Print Name* *Date* *Dentist Signature*