DENTAL and MEDICAL HISTORY

Why have you come to the dentist today?_____

_____

Do you require antibiotics before dental treatment? ☐yes ☐no

Do you smoke or use any form of tobacco? ☐yes ☐no

FOR WOMEN: Are you taking birth control pills? ☐yes ☐no

Are you pregnant? ☐Yes ☐No ☐Unsure Week#_____

Are you nursing? ☐Yes ☐No

Do you have or have you experienced any of the following? Please mark all that apply:

Heart Trouble/Disease ☐	Diabetes ☐	Arthritis ☐	Venereal Disease ☐
High Blood Pressure ☐	Epilepsy/Seizures ☐	Colitis/Crohn's Disease ☐	Drug Addiction ☐
Heart Murmur ☐	Kidney Disease ☐	Radiation Treatment ☐	Alcohol Addiction ☐
Pacemaker ☐	Renal Dialysis ☐	Artificial Joints ☐	Psychiatric Care ☐
Stroke ☐	Thyroid Disease ☐	Tuberculosis (TB) ☐	None of the above ☐
Hemophilia ☐	Sinus Problems ☐	Blood Transfusion ☐	
Asthma ☐	Jaw Surgery ☐	Hepatitis ☐	
Lung Disease ☐	Cancer ☐	AIDS/HIV+ ☐	

Have you ever taken Fosamax, Actonel, Aredia or Zometa? ☐Yes ☐No

Please list any other serious medical conditions_____

Are you taking any prescription/ over the counter drugs? ☐Yes ☐No *If yes, please list each one*: _____

_____

Are you allergic to any of the following?

Aspirin ☐	Dental Anesthetics ☐	Jewelry/Metals ☐	Sulfa Drugs ☐	Penicillin ☐
Codeine ☐	Erythromycin ☐	Latex ☐	Tetracycline ☐	Other ☐

Please list anything additional that causes allergic reactions: _____

_____

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary service I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature_____**Date**_____

MEDICAL HISTORY UPDATE (Do not sign until next exam)

I have read my medical history (above) and confirm that it states past and present medical condition with the following exceptions: ☐none

☐_____

Signature_____ Date_____

I have read my medical history (above) and confirm that it states past and present medical condition with the following exceptions: ☐none

☐_____

Signature_____ Date_____

I have read my medical history (above) and confirm that it states past and present medical condition with the following exceptions: ☐none

☐_____

Signature_____ Date_____

I have read my medical history (above) and confirm that it states past and present medical condition with the following exceptions: ☐none

☐_____

Signature_____ Date_____

I have read my medical history (above) and confirm that it states past and present medical condition with the following exceptions: ☐none

☐_____

Signature_____ Date_____