MEDICAL HISTORY

DIRECTIONS: PLEASE CIRCLE AN ANSWER FOR EVERY QUESTION

1 Patient legal name: _____

2 Are you in good health? _____ Y / N

3 Are you presently under the care of a physician? _____ Y / N

If yes, for what condition? _____

Physician name & phone#: _____

4 Have you had, or do you presently have, any of the following conditions?

Heart surgery, disease or attack	Y / N	Psychiatric treatment / mental disorders	Y / N
Angina pectoris	Y / N	Rheumatic heart disease	Y / N
Congenital heart lesions (MVP)	Y / N	Hepatitis, jaundice or liver disease	Y / N
Artificial heart valve	Y / N	Kidney disease or dialysis	Y / N
Heart valve disease	Y / N	Gastric disorders	Y / N
AIDS or HIV positive	Y / N	High / low blood pressure	Y / N
Test date:		Drug addiction / alcoholism	Y / N
Heart pacemaker	Y / N	Hemophilia / excessive bleeding	Y / N
Other implanted device(s)	Y / N	Blood transfusion	Y / N
Artificial joint / prosthesis	Y / N	Clench or grind your teeth	Y / N
Stroke	Y / N	Jaw joint / TMD problems	Y / N
Sleep apnea	Y / N	Asthma	Y / N
Hearing impairment	Y / N	Diabetes	Y / N
Cancer or tumors	Y / N	Sinus trouble	Y / N
Chemotherapy / x-ray treatment	Y / N	Seizures / Epilepsy	Y / N
Lung disease / Tuberculosis	Y / N	Allergies	Y / N

5 Have you taken cortisone / prednisone or any other steroid in the last two years? _____ Y / N

6 Have you had eye surgery in the last two months? _____ Y / N

7 Have you ever or are you currently undergoing bisphosphonate* therapy? _____ Y / N

**Most commonly used to treat osteoporosis, Paget's disease, bone metastases and multiple myeloma.*

8 Have you ever used any tobacco products? _____ Y / N

If past use only, approximate quit date: _____

9 Have you used cocaine, ecstasy, methamphetamine or any street drug in the last 24 hours? _____ Y / N

These drugs can produce life threatening interactions with some dental anesthetics.
Please inform us at each visit if you have used any of these within the last 24 hours.

10 Do you have significant anxiety regarding dental treatment? _____ Y / N

11 Have you ever had any serious complications involving dental treatment? _____ Y / N

12 WOMEN:

Are you pregnant _____ Y / N if yes, how many months? _____

Are you breast-feeding? _____ Y / N

Please continue on other side ⇨

13 Have you ever had an allergic or unusual reaction to any of the following?

Latex	Y / N	Codeine or other opioids	Y / N
Dental local anesthetics	Y / N	Any other medications or drugs	Y / N
Aspirin, Acetaminophen or ibuprofen	Y / N	If yes, please list:	
Penicillin	Y / N		
Any other antibiotic	Y / N		

14 Have you ever: (if yes, please list)

been hospitalized?	Y / N
had a serious illness?	Y / N
had a major operation?	Y / N

15 Please list any medications, over the counter or prescription, that you are now taking:

A.	E.	I.
B.	F.	J.
C.	G.	K.
D.	H.	L.

16 Please add any information regarding your medical history that may not have been mentioned:

17 I, understand, being the patient or parent/guardian of the above minor patient, that the information above is accurate and true to the best of my knowledge. I give consent to an examination, x-ray and/or CBCT to aid in the diagnosis of my condition. I also understand there is much we are still learning about Covid-19 and the SARS-CoV2 virus; the information is updated daily and there are many unknowns. I understand that interacting with other human beings, including being in this dental office, can increase my risk of contracting Covid-19.

Signed: _____

Signature of patient - or - signature of parent/guardian if patient is a minor Date

For office use only:

DATE:	NOTES / UPDATES: