Marcellus Smiles Family Dentistry Medical History Form

Patient Name _____ **DOB**_____ **Today's Date** _____

Primary Care Physician Name(s)_____

Do you have any **allergies** to medications or substances?
□No □Yes Please list: _____

Women: Are you…
□Pregnant/Trying to get pregnant □Nursing □Taking Oral Contraceptives

Do you have, or have you had, any of the following:

- AIDS/HIV
- Alzheimers/Dementia
- Anemia
- Angina
- Arthritis
- Asthma
- Bleeding Problems
- Cancer/Leukemia
- Chemotherapy
- Migraines
- Diabetes
- Drug Addiction
- Emphysema/COPD
- Epilepsy/Seizures
- Fainting Spells
- Heart Attack
- Heart Pacemaker
- Heart Disease/Surgery
- Clotting Disorder
- Hepatitis B or C
- Herpes
- High Blood Pressure
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Osteoporosis
- Psychiatric Care
- Radiation Treatments
- Sinus Trouble
- Stomach/Intestinal Disease
- Stroke
- Thyroid Disease
- Tuberculosis

Any serious illness or surgery not listed above

_____

_____

Have you ever taken **medications for Osteoporosis/Osteopenia?**
□No □Yes Name of Medication_____
Do you have any **artificial joints or heart valve replacements**
□No □Yes Date and Type of Surgery_____
Do you take any **blood thinners?**
□No □Yes Name of Medication_____

Please list all medications (continue on back or attach list as needed)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Comments:

_____

_____

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_____ _____
Signature of Patient/Parent/Guardian Date