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PATIENT MEDICAL HISTORY FORM

Patient Name: _____

Patient DOB: _____ **Patient Sex:** _____ **Date :** _____

Are you allergic, or have you had a known reaction, to any of the following? *Please circle.*

Aspirin	Barbiturates, Sedatives, or Sleeping Pills
Codeine (or similar Narcotics) _____	Certain Foods _____
Local Anesthetics	Iodine
General Anesthetics	Hay Fever, Pollen, Seasonal Issues
Penicillin (or similar antibiotics) _____	Animal Fur or Dander
Sulfa (or sulfur-containing) drugs	Iodine
Latex or Natural Rubber	Metals or Metallic Substances _____
Other Allergy or Allergies not listed above: _____	

Do you currently have (or have history of) any of the following? *Please circle and state when diagnosed.*

Abnormal Bleeding _____	Heart Surgery _____
Angina _____	Hemophilia _____
Alcohol Abuse _____	Hepatitis (which type, if so) _____
Anemia _____	High Blood Pressure _____
Arthritis _____	Kidney Problems _____
Artificial Heart or Valves _____	Liver Disease _____
Artificial Joints _____	Low Blood Pressure _____
Asthma _____	Mitral Valve Issues _____
Blood Transfusion _____	Pace Maker _____
Cancer/Chemotherapy _____	Pneumocystis/Pneumonia _____
Colitis _____	Rheumatic Fever _____
Congenital Heart Defects _____	Shingles _____
Diabetes _____	Sickle Cell Disease _____

Difficulty Breathing _____	Sinus Issues/Surgery _____
Drug Abuse _____	Stroke _____
Emphysema _____	Thyroid Problems _____
Epilepsy _____	Organ Transplant _____
Fainting, Dizziness, Light-Headedness _____	Tuberculosis _____
Fever Blisters _____	Ulcers _____
Frequent headaches _____	Venereal Disease/STD _____
Glaucoma/Eye Disease _____	Yellow Jaundice _____
HIV/AIDS _____	Other Medical Condition not listed: _____
Hay Fever _____	_____
Heart Attack/Congestive Heart Failure _____	_____

Additional Health Items:

Do you use tobacco products? If so, which one(s) & how often? _____

Do you use recreational drugs? If so, which one(s) & how often? _____

Do you drink alcohol? If so, how often and how much? _____

Any anxiety, depression, or mental health conditions? _____

Are you required to pre-medicate before any dental treatment? If so, by whom and why? _____

Are you pregnant or nursing? If so, how far along are you? _____

Are you currently taking any medications? If so, please list and state what for: _____

Any other health issues, conditions, or procedures that you feel we should be aware of? _____

Please provide Primary Care Doctor name and contact information: _____

Signature

Printed Name

Date

By signing this form, you are agreeing to the following: The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.