Associated Dentists

MEDICAL HISTORY

PATIENT NAME____ BIRTH DATE_________________________

EMERGENCY CONTACT____________________________________ RELATION ___________________ EMERGENCY PHONE _________________

Although dental personnel primarily treat the areas in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications you are taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- **Blood Pressure:** S_______/D_______
- Have you ever been told to take antibiotics prior to dental treatment? ◯ Yes ◯ No If yes, for what reason:______________________________
- Have you ever been hospitalized OR had a major operation? ◯ Yes ◯ No If yes, please explain:______________________________
- Do you use tobacco? ◯ Yes ◯ No What type:________________ Frequency:______________

Women: Are you
◯ Pregnant/trying to get pregnant ◯ Taking oral contraceptives ◯ Nursing

Are you allergic to any of the following?
◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Local Anesthetics
◯ Other If yes, please explain:____

Please check ALL that apply (both past and present)

◯ Acid Reflux/GERD
◯ ADHD
◯ AIDS
◯ Alzheimer's Disease
◯ Anaphylaxis
◯ Anemia
◯ Angina
◯ Arthritis's/Gout
◯ Artificial Heart Valve
◯ Artificial Joint
◯ ASD (autism spectrum disorder)
◯ Asthma
◯ Blood Disease
◯ Blood Transfusion
◯ Breathing problem/Easily winded
◯ Bruise Easily
◯ Cancer
◯ Chemotherapy
◯ Chest Pains
◯ Cold Sores/Fever Blisters
◯ Congenital Heart Disorder
◯ Convulsions
◯ Diabetes (circle: type I or type II)
◯ Dementia
◯ Drug Addiction or Chemical Dependency
◯ Eating Disorder
◯ Emphysema
◯ Epilepsy or Seizures
◯ Excessive Bleeding
◯ Excessive Thirst
◯ Excessive Daytime Sleepiness
◯ Family History of Head/Neck Cancer
◯ Fainting Spells/Dizziness
◯ Hay Fever
◯ Heart Attack/Failure
◯ Heart Pace Maker
◯ Heart Trouble/Disease
◯ Hemophilia
◯ Hepatitis A
◯ Hepatitis B
◯ Hepatitis C
◯ High Blood Pressure
◯ HIV Positive
◯ Hypoglycemia
◯ Irregular Heartbeat
◯ Kidney Problems
◯ Leukemia
◯ Liver Disease
◯ Low Blood Pressure
◯ Lung Disease
◯ Other:_______________
◯ Oral Cancer
◯ Osteoporosis
◯ Pain in Jaw Joints
◯ Pacemaker
◯ Panic Attack, Phobia, Extreme Nervousness
◯ Psychiatric Care
◯ Radiation Treatments
◯ Recent Weight Loss
◯ Sinus Trouble
◯ Sleep Apnea/Snoring
◯ Stomach/Intestinal Disease
◯ Stroke
◯ Thyroid Disease
◯ Tonsillitis
◯ Tuberculosis
◯ Tumors or Growths
◯ Ulcers

Please list current medications you are taking

Prescription:____

____

____

Over the counter & herbal: ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my dental status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN____ DATE _______________