Medical History
New Patients and Returning

YES	NO	
		Are you allergic to any medications?
		Have you been seriously ill in the last five years?

DO YOU HAVE OR HAVE YOU HAD?

		AutoImmune Disorder
		Allergies _____
		Anemia
		Arthritis / Rheumatism
		Asthma / Hay Fever
		Bleeding Problems Type _____
		Blood Disease
		Blood Transfusion / Date _____
		Cancer or Tumor Type / Date _____
		Head Injury
		Heart Trouble/Murmur/Mitral Valve Prolapse (Circle)
		Heart Attack / Date
		Hepatitis (Jaundice) Type _____
		High/Low Blood Pressure (circle)
		Hives or Skin Rash
		HIV / AIDS
		Kidney Disease
		Liver Disease
		Prosthetic Device / Date _____ Location _____
		Pyschological Problems / Depression
		Have you ever been hospitalized?
		Do you need premedication for dental treatment?
		Osteoporosis Treatment

YES	NO	
		Have you ever been COVID-19 Positive?
		If so, when (date)? _____
		Have you had any treatment or Hospitalization from COVID-19?
		Have you had the COVID-19 Vaccine?
		If so, when (date)? _____
		Make of vaccine?_____
		Any reactions from the vaccine?
		If so, when (date)? _____
		Chemotherapy Type & When _____
		Chest Pains (Angina) / Frequency
		Cortisone / Steroids
		Diabetes Type: _____
		Avg Daily Blood Sugar: ____ Last A1C: _____
		Drug Addiction
		Drug Reaction / Type
		Epilepsy (Seizures) / Fainting (Frequent)
		Headaches (Frequent)
		Radiation for Head / Neck Cancer
		Rheumatic Fever / Rheumatic Heart Disease
		Shortness of Breath
		Sinus Trouble
		Stomach / Intestinal Disease (Ulcers)
		Stroke / If yes, when _____
		Swelling of Hands or Feet
		Thyroid Disease
		Tuberculosis / Lung Disease
		Do you have any OTHER medical conditions?

_____

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS:

		Antibiotics (Penicillin, etc.) List: _____
		Anticoagulants (Blood Thinners, Vitamin E)
		Last INR _____ Date _____
		Antihistamines (Benadryl, etc.)
		Aspirin (Advil, Nuprin, etc.)
		Cortisone (Steroids)
		Digitalis (Heart Medication)

		Bisphosphonates (Ex: Prolia, Boniva, Fosamax)
		Insulin (Diabetes Medication)
		High Blood Pressure Medication
		Nitroglycerin
		Sulfa Drugs
		Tranquilizers
		LIST ALL MEDICATIONS TAKEN

_____

_____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:

		Antibiotics (Penicillin, etc.) List: _____
		Barbiturates (Sedatives or Sleeping Pills)
		Iodine
		Latex

		Local Anesthetics List: _____
		Narcotics (Codeine, etc.) List: _____
		Sulfa Drugs
		OTHER _____

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YES	NO	WOMEN ONLY:
		Are you pregnant? What month? _____
		Are you in or have you been through menopause?
		Are you taking birth control pills?

DENTAL INFORMATION - DO YOU:

YES	NO	
		Have any dental pain or problems now?
		Grind or frequently clench your teeth?
		Have an unpleasant taste in your mouth?
		Gums bleed when brushing or flossing?
		Brush your teeth at least twice per day?
		Had problems with dental anesthesia (Novocaine)?
		Noticed any shifting of your teeth?
		Ever had periodontal (gum) surgery?
		Date of most recent dental cleaning _____
		Use any tobacco products?

Additional Information

_____
_____
_____
_____
_____
_____

Print Name _____ **Date** _____

Signature _____ **Date** _____

Parent or Guardian

Our dental providers are not affiliated. Each doctor is soley responsible for the care they provide.