MEDICAL HISTORY - CONFIDENTIAL

Patient Full Name*

Patient Birth Date*

Name of Primary Care Physician

Are you taking any medications at this time?

☐ Yes

☐ No

Medication	Reason
Medication	Reason
Medication	Reason
Medication	Reason
Medication	Reason
Medication	Reason
Medication	Reason
Medication	Reason

Have you had allergic or adverse reactions to any medications or local anesthetics?

☐ Yes ☐ No

If so, please list

Do you have or have you had any of the following?

- [ ] Heart Trouble
- [ ] Heart Attack
- [ ] Stroke
- [ ] Heart Murmur
- [ ] Valve Prolapse
- [ ] Valve Replacement
- [ ] Rheumatic Fever or Rheumatic Heart Disease
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Liver Disease
- [ ] Hepatitis
- [ ] Cirrhosis
- [ ] Asthma
- [ ] Emphysema
- [ ] Bone Cancer
- [ ] Osteoporosis
- [ ] Hay Fever
- [ ] Tuberculosis
- [ ] Do You Smoke?
- [ ] Blood Disorders
- [ ] HIV Positive/AIDS
- [ ] Alcoholism
- [ ] Depression
- [ ] Diabetes
- [ ] Thyroid Disease
- [ ] Kidney Disease
- [ ] Arthritis
- [ ] Radiation Treatment
- [ ] Chemotherapy
- [ ] Seizures or Epilepsy

Prosthetic or Artificial Joint Replacement?

- [ ] Yes
- [ ] No

If so, when?

Is there any other significant medical information that might affect your dental treatment?

Women: Are you taking oral contraceptives or other hormones?

- [ ] Yes
- [ ] No

Are you pregnant?

- [ ] Yes
- [ ] No

If so, when is your due date?