medical history

Name _____ Birthday _____

medical care

Primary care physician's name _____ Phone (___) _____

Office Address _____

Have you had any medical visits in the last two years that weren't for regular check-ups?

Have you been hospitalized in the last five years? If so, for what?

conditions

Do you have any known allergies?

Are you/do you think you might be pregnant?

◯ Yes ◯ No ◯ I'm not sure

If yes, how far along are you? _____

Are you currently nursing?

◯ Yes ◯ No

Do you currently take birth control? ◯ Yes ◯ No

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Please check any of the following with which you have had issues:

- ☐ Heart (Surgery, disease, attack)
- ☐ Chest pain
- ☐ Congenital heart disease
- ☐ Heart murmur
- ☐ High/Low blood pressure
- ☐ Heart valve prolapse
- ☐ Artificial heart valve
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Artificial joints
- ☐ Kidney problems
- ☐ Ulcers
- ☐ Diabetes
- ☐ Thyroid issues
- ☐ Glaucoma
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Tuberculosis
- ☐ COVID
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ Tumors
- ☐ Hepatitis A/B/C
- ☐ Untreated sexually transmitted infection
- ☐ HIV or AIDS
- ☐ Cold sores
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Liver disease
- ☐ Neurological disorders
- ☐ Epilepsy or seizures
- ☐ Fainting or vertigo
- ☐ Dental anxiety

Please list any disease, condition, or problem not listed above:

medications

Have you ever taken a weight-loss pill by the name of Fen-Phen, Pondimen, or Redux? ◯ Yes ◯ No

Have you ever taken a bone loss prevention medication such as Fosamax, Actonel, Boniva, or a similar medication? ◯ Yes ◯ No

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Please list any medications or supplements you are currently taking:

Medication/Supplement:	*Reason for taking it:*

acknowledgement

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Name _____ **Date** _____

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