Date___________________ Weight(lbs):_________

Medical History Form

Patient Name ____ Birth Date (Age)____________________(____)

Physician's Name/Location____

Primary Contact #:____________________________ Emergency Contact #:______________________________

Email: ____

Allergies – Are you allergic to any of the following?

Local Anesthetics (e.g., novocaine)	☐Yes	☐No	Sedatives (e.g., Halcion)	☐Yes	☐No
Penicillins or other Antibiotics	☐Yes	☐No	Iodine	☐Yes	☐No
Sulfa Drugs	☐Yes	☐No	Aspirin/Ibuprofen/Tylenol	☐Yes	☐No
Latex	☐Yes	☐No	Metal (e.g., Nickel, Copper, Silver)	☐Yes	☐No
Opioids (e.g., Codeine, Hydrocodone)	☐Yes	☐No	Acrylic	☐Yes	☐No
Barbituates (e.g., sleeping pills)	☐Yes	☐No	Other____		

General Health

Are you currently under medical treatment?	☐Yes	☐No	If yes, explain_____________________________
Have you ever been hospitalized or had a major operation?	☐Yes	☐No	If yes, explain_____________________________
Have you taken Phen-Fen or Redux?	☐Yes	☐No	If yes, explain_____________________________
Do you use controlled substances?	☐Yes	☐No	If yes, explain_____________________________

Women: Are you…

Pregnant/Trying to get pregnant? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

ONJ Risk: Do you have a history of…

Osteoporosis/Osteopenia	☐Yes	☐No
Cancer	☐Yes	☐No
Radiation Therapy	☐Yes	☐No
Chemotherapy	☐Yes	☐No
Taking medications such as the following:		
- IV Bisphosphonates (e.g., Zometa or Aredia)	☐Yes	☐No
- Oral Bisphoshonates (e.g., Fosamax/Boniva)	☐Yes	☐No
- Monoclonal antibodies (e.g., Demosumab)	☐Yes	☐No
- Multikinase inhibitor (e.g., Sunitinib)	☐Yes	☐No

Delayed Healing Risk: Do you have a history of…

AIDS/HIV	☐Yes	☐No
Anemia	☐Yes	☐No
Blood Disease	☐Yes	☐No
Bruise Easily	☐Yes	☐No
Diabetes	☐Yes	☐No
Excessive Bleeding	☐Yes	☐No
Hemophilia	☐Yes	☐No
Sickle Cell Disease	☐Yes	☐No

Premedication Need: Do you have a history of…

Artificial Joint Replacement	☐Yes	☐No
Artificial Heart Valve	☐Yes	☐No
Congenital Heart Defects	☐Yes	☐No
Endocarditis	☐Yes	☐No
Has a physician or dentist ever told you that you will need to take antibiotics prior to dental appointments?	☐Yes	☐No

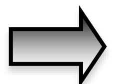
Oral Cancer Risk: Do you have a history of…

Tobacco use	☐Yes	☐No
Alcohol use	☐Yes	☐No
Oral Cancer in your family	☐Yes	☐No
Human Papilloma Virus (HPV)	☐Yes	☐No

Comments

Staff Use Only: **Medical Alerts**

More questions on back



Heart/Vascular Conditions			Lung/Breathing Conditions			Kidney/Liver Conditions		
Angina or Chest Pains	☐Yes	☐No	Asthma	☐Yes	☐No	Blood Transfusion	☐Yes	☐No
Heart Attack	☐Yes	☐No	Breathing Problem	☐Yes	☐No	Hepatitis A	☐Yes	☐No
Heart Disease	☐Yes	☐No	Easily Winded	☐Yes	☐No	Hepatitis B / C	☐Yes	☐No
Heart Murmur	☐Yes	☐No	Emphysema/COPD	☐Yes	☐No	Kidney Problems	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Frequent Cough	☐Yes	☐No	Liver Disease	☐Yes	☐No
High Cholesterol	☐Yes	☐No	Lung Disease	☐Yes	☐No	Renal Dialysis	☐Yes	☐No
Irregular Heartbeat	☐Yes	☐No	Sleep Apnea	☐Yes	☐No	Yellow Jaundice	☐Yes	☐No
Low Blood Pressure	☐Yes	☐No	Hyperventilation	☐Yes	☐No			
Mitral Valve Prolapse	☐Yes	☐No						
Pacemaker	☐Yes	☐No						
Rheumatic Fever	☐Yes	☐No						
Stroke	☐Yes	☐No						

Other Conditions

Alzheimer's Disease	☐Yes	☐No	Genital Herpes	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Anaphylaxis	☐Yes	☐No	Glaucoma	☐Yes	☐No	Shingles	☐Yes	☐No
Arthritis/Gout	☐Yes	☐No	Hay Fever	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Convulsions	☐Yes	☐No	Herpes	☐Yes	☐No	Spina Bifida	☐Yes	☐No
Cortisone Medicine	☐Yes	☐No	Hives/Rash	☐Yes	☐No	Stomach Disease	☐Yes	☐No
Cold Sores	☐Yes	☐No	Hypoglycemia	☐Yes	☐No	Swelling of Limbs	☐Yes	☐No
Drug Addiction	☐Yes	☐No	Intestine Disease	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Eating Disorder	☐Yes	☐No	Leukemia	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Epilepsy/Seizures	☐Yes	☐No	Parathyroid Disease	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Excessive Thirst	☐Yes	☐No	Psychiatric Care	☐Yes	☐No	Tumors or Growths	☐Yes	☐No
Fainting Spell	☐Yes	☐No	Recent Weight Loss	☐Yes	☐No	Ulcers	☐Yes	☐No
Frequent Diarrhea	☐Yes	☐No	Rheumatism	☐Yes	☐No	Venereal Disease	☐Yes	☐No

Have you ever had any serious illness not listed in this form? ☐Yes ☐No ______________________________

Medications -Please list all medications you are currently taking including herbal medicines

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

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 dentist office of any changes in medical status.

Signature of PATIENT, PARENT, or GUARDIAN______________________________Date______________