

## Medical History

\_\_\_\_\_  
Patient First Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Patient Birth Date

Are you under the care of a physician? Yes / No  
Please add your physician name and contact information here

\_\_\_\_\_

Have you ever been hospitalized or had a major operation? Yes / No

\_\_\_\_\_

Have you ever had a serious head or neck injury? Yes / No

\_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? Yes / No

\_\_\_\_\_

Do you or have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes / No

\_\_\_\_\_

Are you on a special diet? Yes / No

\_\_\_\_\_

Do you use tobacco? Yes / No

\_\_\_\_\_

Do you use controlled substances? Yes / No

\_\_\_\_\_

Has a physician or previous dentist recommended that you take antibiotics or pre-medication prior to your dental appointment? Yes / No

\_\_\_\_\_

Do you take any blood thinners? Yes / No

\_\_\_\_\_

Have you ever had endocarditis? Yes / No

\_\_\_\_\_

Were you born with a congenital heart defect? Yes / No

\_\_\_\_\_

Do you have an artificial heart valve? Yes / No

\_\_\_\_\_

Are you allergic to Penicillin? Yes / No

\_\_\_\_\_

Do you have any artificial joints? Yes / No

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Are you pregnant or trying to get pregnant? Yes / No

Are you nursing? Yes / No

Are you taking oral contraceptives? Yes / No

## Do you have any allergies?

### Allergies

- |                                                          |                                                    |
|----------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Animals                         | <input type="checkbox"/> Barbiturates or sedatives |
| <input type="checkbox"/> Codeine or other narcotics      | <input type="checkbox"/> Food                      |
| <input type="checkbox"/> Iodine                          | <input type="checkbox"/> Latex                     |
| <input type="checkbox"/> Local anesthetics               | <input type="checkbox"/> Metals                    |
| <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> Seasonal                  |
| <input type="checkbox"/> Sulfa drugs                     |                                                    |
| <input type="checkbox"/> Other                           |                                                    |

Please add any details here

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## Do you have any medical conditions? We need this information to keep you healthy and safe

### Lung or Breathing Conditions

- |                                    |                                          |
|------------------------------------|------------------------------------------|
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Bronchitis      |
| <input type="checkbox"/> COPD      | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis    |

### Neurological Conditions

- |                                       |                                                     |
|---------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Autism       | <input type="checkbox"/> Brain aneurysm             |
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Epilepsy                   |
| <input type="checkbox"/> Fainting     | <input type="checkbox"/> Migraines/severe headaches |
| <input type="checkbox"/> Seizures     | <input type="checkbox"/> Stroke                     |

### Heart or Circulatory Conditions

- |                                                         |                                                   |
|---------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Angina                         | <input type="checkbox"/> Arteriosclerosis         |
| <input type="checkbox"/> Artificial heart valve         | <input type="checkbox"/> Cardiovascular disease   |
| <input type="checkbox"/> Congenital Heart Disease (CHD) | <input type="checkbox"/> Congestive heart failure |
| <input type="checkbox"/> Damaged heart valves           | <input type="checkbox"/> Heart attack             |
| <input type="checkbox"/> Heart murmur                   | <input type="checkbox"/> Heart transplant         |
| <input type="checkbox"/> High blood pressure            | <input type="checkbox"/> Infective endocarditis   |
| <input type="checkbox"/> Low blood pressure             | <input type="checkbox"/> Mitral valve prolapse    |
| <input type="checkbox"/> Pacemaker                      | <input type="checkbox"/> Pulmonary embolism       |
| <input type="checkbox"/> Rheumatic heart disease        |                                                   |

### Digestive or Dietary Conditions

- |                                                           |                                                      |
|-----------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Acid reflux/persistent heartburn | <input type="checkbox"/> Eating disorder             |
| <input type="checkbox"/> Excessive urination              | <input type="checkbox"/> Gastrointestinal disease    |
| <input type="checkbox"/> Malnutrition                     | <input type="checkbox"/> Severe or rapid weight loss |
| <input type="checkbox"/> Special diet                     |                                                      |

### Autoimmune Conditions

- |                                                 |                                             |
|-------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Celiac disease     |
| <input type="checkbox"/> HIV or AIDS            | <input type="checkbox"/> Immune deficiency  |
| <input type="checkbox"/> Lupus                  | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Rheumatoid arthritis   |                                             |

General Diseases

- ☐ Anemia
- ☐ Cancer
- ☐ Glaucoma
- ☐ Jaundice or Liver disease
- ☐ Renal/Kidney problems
- ☐ Sleep Apnea
- ☐ Other

Please add any details here

- ☐ Bleeding disorder/Hemophilia
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Osteoporosis
- ☐ Sexually transmitted disease
- ☐ Total joint replacement

Do you take any medications?

Pain Medications

- ☐ Aspirin
- ☐ Demerol (Meperidine)
- ☐ Ibuprofen
- ☐ Ultram (Tramadol)

- ☐ Codeine
- ☐ Hydrocodone (Vicodin/Lortan/Norco)
- ☐ Percocet (Oxycodone)

Antibiotics

- ☐ Amoxicillin
- ☐ Clindamycin
- ☐ Tetracycline

- ☐ Ciprofloxacin
- ☐ Doxycycline
- ☐ Zithromax (Azithromycin)

Antidepressant and Anxiety

- ☐ Adderall
- ☐ Celexa (Citalopram)
- ☐ Effexor (Venlafaxine)
- ☐ Neurontin (Gabapentin)

- ☐ Ambien (Zolpidem)
- ☐ Cymbalta (Duloxetine)
- ☐ Lexapro (Escitalopram)

Allergy or Asthma

- ☐ Claritin (Loratadine)
- ☐ Singulair (Montelukast)
- ☐ Zyrtec (Cetirizine)

- ☐ Flonase (Fluticasone)
- ☐ Ventolin (Albuterol Inhaler)

Diabetes, Cholesterol, or Blood Pressure

- ☐ Avapro (Irbesartan)
- ☐ Coumadin (Warfarin)
- ☐ Klor-Con (Potassium Chloride)
- ☐ Lipitor (Atorvastatin Calcium)
- ☐ Losartan (Cozaar)
- ☐ Microzide (Hydrochlorothiazide)
- ☐ Plavix (Clopidogrel)
- ☐ Prinivil (Lisinopril)
- ☐ Toprol XL (Metoprolol)
- ☐ Zestoretic (Lisinopril)

- ☐ Coreg (Carvedilol)
- ☐ Crestor (Rosuvastatin)
- ☐ Lasix (Furosemide)
- ☐ Lopressor (Metoprolol)
- ☐ Metformin (Glucophage)
- ☐ Norvasc (Amlodipine)
- ☐ Pravachol (Pravastatin)
- ☐ Tenormin (Atenolol)
- ☐ Tricor (Fenofibrate)
- ☐ Zocor (Simvastatin)

General Medications

- ☐ Aclasta/Reclast (Zoledronic Acid)
- ☐ Cialis (Tadalafil)
- ☐ Didronel (Etidronate)
- ☐ Medrol (Methylprednisolone)
- ☐ Pantoprazole (Protonix)
- ☐ Prilosec (Omeprazole)
- ☐ Other

- ☐ Boniva (Ibandronate)
- ☐ Cyclobenzaprine (Flexeril)
- ☐ Fosamax (Alendronate)
- ☐ Meloxicam (Mobic)
- ☐ Prednisone
- ☐ Synthroid (Levothyroxine)

Please add any details here

Have you ever had any serious illness not listed above? Yes / No

I certify that I have read and I understand the questions asked. I certify I have answered these questions in completion and do not hold the practice, doctor(s), or team responsible for any errors or omission that I have made in completing these forms.

☐ I agree the above information is correct to the best of knowledge

|                                                                                             |                    |
|---------------------------------------------------------------------------------------------|--------------------|
| _____                                                                                       | _____              |
| <b>Signature By Patient</b>                                                                 | <b>Date Signed</b> |
| By signing above I understand and agree that this is a legal representation of my signature |                    |

|                                                                                             |                      |
|---------------------------------------------------------------------------------------------|----------------------|
| _____                                                                                       | _____                |
| <b>Guardian Name</b>                                                                        | <b>Relationship*</b> |
| _____                                                                                       | _____                |
| <b>Signature By Guardian</b>                                                                | <b>Date Signed</b>   |
| By signing above I understand and agree that this is a legal representation of my signature |                      |