

MEDICAL HISTORY

Patient Name: _____

Birth Date: _____

Are you in good health? ☐ Yes ☐ No Height _____ Weight _____Are you currently taking or planning to take antibiotics before dental treatment? ☐ Yes ☐ NoHave you been hospitalized in the past five years? ☐ Yes ☐ NoHave you ever had general anesthesia? ☐ Yes ☐ NoAre you under care of a physician? ☐ Yes ☐ NoHave you or your family had reactions to general anesthesia? ☐ Yes ☐ No

Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years?

☐ Yes ☐ No

WOMEN ONLY

1-4 below for women only:

(Note: antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy?

☐ Yes ☐ No

2) Expected delivery date _____

3) Are you nursing?

☐ Yes ☐ No

4) Are you taking birth control pills?

☐ Yes ☐ No

ALLERGIES/REACTIONS

Y N☐ ☐ Penicillin☐ ☐ Aspirin**Y N**☐ ☐ Sulfa drugs☐ ☐ Codeine or other
narcotics**Y N**☐ ☐ Local anesthetic☐ ☐ Latex**Y N**☐ ☐ Amoxicillin☐ ☐ Do you have any known
allergies

Please list any allergies not listed above

MEDICAL CONDITIONS

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y N☐ ☐ AIDS / HIV☐ ☐ Alzheimer's☐ ☐ Anemia☐ ☐ Arthritis / Joint disease☐ ☐ Asthma☐ ☐ Bleeding tendency☐ ☐ Blood transfusion☐ ☐ Bronchitis☐ ☐ Bruise easily☐ ☐ Cancer☐ ☐ Chest pain / Angina☐ ☐ Chronic cough☐ ☐ Chronic fatigue / Night
sweat☐ ☐ Convulsions / Epilepsy☐ ☐ Delay in healing**Y N**☐ ☐ Dementia☐ ☐ Diabetes☐ ☐ Do you smoke or vape

Number of smoke/day _____

☐ ☐ Do you use chewing
tobacco☐ ☐ Emphysema☐ ☐ Eye disease /
Glaucoma☐ ☐ Fainting spells☐ ☐ Hay fever / Sinus
problems☐ ☐ Heart attack(s)☐ ☐ Heart murmur☐ ☐ Heart pacemaker☐ ☐ Heart surgery☐ ☐ Osteoporosis☐ ☐ Hepatitis**Y N**☐ ☐ High blood pressure☐ ☐ High cholesterol☐ ☐ History of alcohol / drug
abuse☐ ☐ History of marijuana /
drug use☐ ☐ Infectious
mononucleosis☐ ☐ Irregular heart beat☐ ☐ Joint replacement☐ ☐ Kidney trouble☐ ☐ Liver disease☐ ☐ Low blood pressure☐ ☐ Low blood sugar☐ ☐ Mental health problems☐ ☐ Osteopenia☐ ☐ Heart valve issues☐ ☐ Problems with immune
system**Y N**☐ ☐ Prosthetic implant☐ ☐ History of Radiation☐ ☐ Respiratory problems☐ ☐ Rheumatic fever☐ ☐ Sexually transmitted
diseases☐ ☐ Sleep apnea / CPAP☐ ☐ Special diet☐ ☐ Stomach ulcers / acid
reflux☐ ☐ Stroke☐ ☐ Thyroid trouble☐ ☐ Trouble climbing 1-2
flights of stairs☐ ☐ Tumor or growth☐ ☐ Headache☐ ☐ Pneumonia☐ ☐ Have you had infective
endocarditis ?

Any other medical conditions not listed above

MEDICATIONS

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

PATIENT SIGNATURE

X

X

Signature of patient

Date

DOCTOR'S NOTES

X

X

Signature of dentist

Date