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Medical History Form

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

On required * questions, please write N/A if question(s) does not apply

Medical History:

Sleep:

Primary Care Physician:

Does your physician recommend that you pre-medicate prior to your dental appointment(s)? * ◯ Yes ◯ No

List Pre-Med information:

Do you take Aspirin Daily 81mg or any other blood thinner(s)? * ◯ Yes ◯ No

Do you have any allergies and/or allergies to medications?: * ◯ Yes ◯ No

List Allergies:

Have you ever taken medication, such as Fosomax, for Osteoporosis? * ◯ Yes ◯ No

Are you taking any medications (include prescription, over the counter, vitamins, supplements)? * ◯ Yes ◯ No

List Medications: *

Please indicate which of the following you have been diagnosed with & include PASTdiagnoses. ***Select, No Medical Condition if non apply to you.

- ☐ AIDS
- ☐ Allergies
- ☐ Allergy, Medicines
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Cardiac Disease
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Endocarditis
- ☐ Endocrine Disorders
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ G.I. Disorders
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Neurological Disor..
- ☐ No Epinephrine
- ☐ No Medical Condition
- ☐ Organ Transplant
- ☐ Other
- ☐ Pacemaker
- ☐ Premedicate
- ☐ Psychological
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sleep Disorders
- ☐ STD/HPV
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. I further consent to the performing of xrays and oral examinations. This will serve as my electronic signature.**

Name of Patient/Parent or Guardian completing this form *

_____

_____

_____

Response Date: ____/____/_____