MEDICAL HISTORY **ALLERGIES:** _____ **Height:** ____' ____" **Weight:** ____ lbs.

Name: _____ **Preferred Name:** _____

Chief Complaint (Reason you are here): _____

Circle yes (Y) or no (N)

Y N Are you in good health? Date of last physical? _____
Y N Are you under a physician's care for a particular problem? If yes, what? _____
Y N Have you ever had excessive bleeding requiring special treatment?
Y N Have you or any blood relatives ever had adverse effects from surgery, anesthesia or dental treatment? If yes, please explain:
_____
Y N Do you smoke cigarettes /cigars /pipe or dip/chew tobacco? If yes, what and how much? _____
Y N Do you drink? If yes, what? Beer / Alcohol / Wine? What & How much? _____
Y N Are you taking any vitamins or herbal supplements? If so, what? _____

Please list all surgeries or operations within the last 5 years: _____

Circle any of the follow medications you are currently taking:

Anticoagulants (Blood Thinners) Bisphosphonates (Fosamax/Actonel for osteoporosis, Chemotherapy for multiple myeloma, etc.)
Insulin, Diabinese, or similar drug Steroids (Cortisone, etc.)
Heart Medication or BP Medication Diet Pills: *Fen-Phen* (fenfluramine & phentermine), Pondium (fenfluramine), Redux (dexfenfluramine), etc.

Y N Have you in the past or are you presently using marijuana or other "street drugs"? What have you used and when? _____

Please list ***All Medications*** or pills presenting taken. **If no medications are taken, please check here:** ☐

Medication Dosage Reason for taking

1. _____
2. _____
3. _____

Circle any of the following that you have had or have at present:

AIDS/HIV	Emphysema	High blood pressure	Reaction to latex
Anemia	Epilepsy or seizures	Immune System/Organ	Reflux / Hyperacidity
Arthritis	Fainting or dizzy spells	Transplant	Rheumatic fever
Artificial heart valve	Frequent Respiratory	Irregular heart beat	Rheumatism
Artificial Joint	Infections	Jaundice	Sickle cell disease
Asthma	Glaucoma	Kidney Trouble	Sinus trouble
Blood transfusion	Growth/Tumor	Liver disease	Sleep Apnea
Bruise easily	Hay fever	Low blood pressure	Steroid medicine
Cancer	Heart Attack or Angina	Lupus	Stroke
Chemotherapy (cancer, leukemia)	Heart failure	Mitral valve prolapse	Swollen ankles
	Heart murmur	Persistent Cough	Thyroid disease
Cold Sores	Heart Pacemaker	Porphyria	Tuberculosis
Congenital heart defect	Hepatitis A (infectious)	Psychiatric Treatment	Type I Diabetes
CPAP	Hepatitis B	Radiation or x-ray treatment	Type II Diabetes
Drug addition or alcoholism	Hepatitis C	Reaction to iodine	Ulcers(Stomach, etc.)

WOMEN: **Are you/might you be pregnant? Y N Are you breastfeeding? Y N**

Please list any medical conditions or illnesses not listed above: _____

Are you allergic or had a reaction to:

Y N Local Anesthetics Y N Peanuts, soybeans, or eggs Y N Penicillin or antibiotics
Y N Latex Y N Other _____ _____

If yes to any of the above allergies, please describe reaction: _____

Y N Do you have problems (pain/popping/clicking) with your jaw joints (TMJ)? Explain? _____
Y N Are you wearing a removable dental appliance?

Is there anything else the doctor should know? _____

Please read and sign:

I have read and completed this medical history form with complete, true and accurate information. If I ever have any change in health or medications, I will inform the doctor at the next appointment without fail. I have been offered a copy of the "Notice of Privacy Practices for Protected Health Information" form and given an opportunity to ask questions. I have reviewed the above list carefully and circled all illnesses that apply. If none of the above are circled, I acknowledge that these conditions do not apply to my health status.

_____/____/_____ _____ _____

Date **Patient, Parent or Guardian's Signature** **Doctor Signature**