



Please fill out this form as completely as possible. The better we communicate, the better we can care for you!

Name _____ I prefer to be called _____
 DOB _____ SS# _____ Email Address _____
 Address _____ City _____ Zip Code _____
 Phone # _____ Cell # _____ Employer _____ Phone # _____
 Emergency Contact: _____ Phone# _____ Relation _____
 Physician _____ Date of Last Physical Exam _____ Date of Last Dental Exam _____

DO YOU, OR HAVE YOU EVER, HAD ANY OF THE FOLLOWING?

Breathing/respiratory problems	Y	N	Diabetes	Y	N
Asthma	Y	N	Artificial Bones, Joints, Valves (circle one)	Y	N
History of tuberculosis (TB)	Y	N	Depression/Psychiatric Problems (circle one)	Y	N
High/low blood pressure (circle one)	Y	N	Alcohol or Drug Abuse (circle one)	Y	N
Stroke	Y	N	Fibromyalgia	Y	N
Heart Attack/Angina (circle one)	Y	N	Sleep Apnea	Y	N
Heart Surgery/Pacemaker(circle one)	Y	N	Cancer (If yes, what type of cancer?)	Y	N
Congenital Heart Defect	Y	N	Chemotherapy	Y	N
Artificial Heart Valves	Y	N	Radiation Therapy	Y	N
Coronary Artery Disease	Y	N	<u>ALLERGIES TO ANY OF THE FOLLOWING:</u>		
Mitral Valve Prolapse	Y	N	Latex	Y	N
Rheumatic Fever	Y	N	Penicillin	Y	N
Ulcer, GERD, Colitis (circle one)	Y	N	Codeine, Aspirin, or other pain meds	Y	N
Epilepsy/Seizures (circle one)	Y	N	Dental Anesthetics	Y	N
Liver Disease	Y	N	Other	Y	N
Hepatitis A, B, or C (circle one)	Y	N	If yes, please explain _____		
HIV positive	Y	N	<u>FEMALE PATIENTS ONLY:</u>		
Osteoporosis If yes, have you taken	Y	N	Pregnant or Nursing	Y	N
Bisphosphonates? _____			Using a prescribed method of birth control	Y	N

Have you ever had any serious medical conditions not listed on this form? _____

Have you been hospitalized in the past 5 years and for what? _____

Do you smoke or use tobacco of any form? _____ Are you interested in quitting? _____

Are you currently or have you ever taken blood thinners? Y N If yes, please list _____

Why have you come to the dentist today? _____ Have you ever required antibiotics before dental treatment? _____

Please list each prescription drug you are taking:

Signature _____

Date _____

Review of Medical History

1. _____
 Signature Date

2. _____
 Signature Date

3. _____
 Signature Date

4. _____
 Signature Date