



# Medical History

Date \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Yes  No  Are you under the care of a Medical Doctor? Physician Name: \_\_\_\_\_

Yes  No  Have you been hospitalized during the past 2 yrs? \_\_\_\_\_

List all medications/vitamins/supplements taken: Pharmacy: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No  Are you allergic to any drugs/medications (Penicillin, Local Anesthetic, Latex, etc.)? List:

Yes  No  Have you taken the diet drug Phentermine/Fenfluramine/Dexfenfluramine?

Yes  No  Have you ever taken Fosomax or similar medications for bone density?

Yes  No  Do you use a C-PAP machine or have you been diagnosed with sleep apnea?

Yes  No  Have you taken any recreational drugs in the past or currently?

Yes  No  Do you use any form of tobacco, smoke, or vape?

### PLEASE CHECK PAST OR PRESENT MEDICAL CONDITIONS BELOW:

Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Failure	Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Disease
Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/> Angina Pectoris
Yes <input type="checkbox"/> No <input type="checkbox"/> High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/> Rheumatic Fever
Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/> Artificial Heart Valve
Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Transfusion	Yes <input type="checkbox"/> No <input type="checkbox"/> Anemia
Yes <input type="checkbox"/> No <input type="checkbox"/> Damaged Heart Valves	Yes <input type="checkbox"/> No <input type="checkbox"/> Stroke
Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Disease	Yes <input type="checkbox"/> No <input type="checkbox"/> Congenital Heart Defect
Yes <input type="checkbox"/> No <input type="checkbox"/> Excessive Bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/> Autoimmune Disease
Yes <input type="checkbox"/> No <input type="checkbox"/> Arthritis/Rheumatism	Yes <input type="checkbox"/> No <input type="checkbox"/> Osteoporosis
Yes <input type="checkbox"/> No <input type="checkbox"/> Artificial Joint	Yes <input type="checkbox"/> No <input type="checkbox"/> Sinus Trouble
Yes <input type="checkbox"/> No <input type="checkbox"/> Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/> Kidney Disease
Yes <input type="checkbox"/> No <input type="checkbox"/> Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/> HIV/AIDS
Yes <input type="checkbox"/> No <input type="checkbox"/> Cancer/Chemotherapy/Radiation	Yes <input type="checkbox"/> No <input type="checkbox"/> Diabetes
Yes <input type="checkbox"/> No <input type="checkbox"/> Thyroid Disease	Yes <input type="checkbox"/> No <input type="checkbox"/> Gastrointestinal Disease
Yes <input type="checkbox"/> No <input type="checkbox"/> Eating Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/> Hepatitis/Liver Disease
Yes <input type="checkbox"/> No <input type="checkbox"/> Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/> Epilepsy/Seizures
Yes <input type="checkbox"/> No <input type="checkbox"/> Alcoholic/Drug Abuse	Yes <input type="checkbox"/> No <input type="checkbox"/> Emphysema
Yes <input type="checkbox"/> No <input type="checkbox"/> Chronic Cough	Yes <input type="checkbox"/> No <input type="checkbox"/> Neurological Disorder
Yes <input type="checkbox"/> No <input type="checkbox"/> Fainting/Dizzy Spells	Yes <input type="checkbox"/> No <input type="checkbox"/> Psychiatric Treatment
Yes <input type="checkbox"/> No <input type="checkbox"/> Mental Health Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/> Recurrent Infection
Yes <input type="checkbox"/> No <input type="checkbox"/> Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/> Excessive Weight Loss/Gain
Yes <input type="checkbox"/> No <input type="checkbox"/> Severe Headaches/Migraines	Yes <input type="checkbox"/> No <input type="checkbox"/> Pregnant/anticipate becoming pregnant
Yes <input type="checkbox"/> No <input type="checkbox"/> Other (please list)	

All information is confidential, to the best of my knowledge all of the preceding answers are true and correct. If I ever have any changes in my health or medication, I will inform the Dentist at the next appointment.

Signature of Patient, Parent or Guardian

Date \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_