Medical History: **Name** _____ **Birthdate** _____ **Date** _____

Physician's Name? _____ Address? _____

Last Visit? _____ Phone? _____

For what? _____

Are you currently under treatment for anything by your physician? If so, please explain?

Are you currently taking any MEDICATIONS or SUPPLEMENTS? If so, please list all with dosage and frequency:

Medicine or Supplement	Dose	Frequency		Medicine or Supplement	Dose	Frequency		Medicine or Supplement	Dose	Frequency

Are you taking bone building medications? O Yes O No *Fosomax, Aredia, Didronel, Actonel, Zometa, Reclast, Boniva*

Are you allergic or had any adverse reaction to any medications? If yes, please list _____,

_____, _____, _____, _____.

Aspirin, Darvon, Codeine, Nitrous Oxide, Erythromycin, Tetracycline, Valium, Penicillin, Local Anesthetics

Have you been hospitalized or had surgery in the last 6 months? Height

Weight

Do you have any food allergies? O Yes O No

Do you use tobacco? If yes, how and how much? _____ When did you quit? _____

Do you use alcohol? If yes, how much? _____

Any current drug addiction? If yes, what and how much? _____

Please circle any of the following which you have had or have at the present:

Heart problems:
Heart attack: *when* _____
Artificial heart valve
Arrhythmia
Angina
Congenital heart lesions
Heart murmur
High blood pressure
Pacemaker or defibrillator
Rheumatic, scarlet fever
Stroke

Breathing problems:
Emphysema or COPD
Tuberculosis
Asthma- daily use of puffer _____
Sinus trouble or hay fever
Sleep apnea

Seizures:

Fainting or dizziness:

Venereal disease:
STD's or Genital herpes
AIDS
Tested positive for HIV

Diabetes: Type I or Type II

Thyroid disease:

Blood Problems:
Anemia
Hemophilia
Leukemia
Prolonged bleeding
Sickle cell anemia
Blood thinners:
Coumadin, Warfarin, Plavix

Cancer:
What & when:
Chemotherapy
Radiation treatments

Psychiatric treatment:

Liver problems:
Jaundice
Hepatitis A (infectious)
Hepatitis B (serum)
Hepatitis C

Kidney problems:

Stomach problems:
Bulimia
Gastric reflux disease
Ulcers

Previous problem with anesthsia or sedation?

Previous drug user:

Arthritis
Pain in joints

Allergies or hives
Latex

Fibromyalgia

Trauma to jaw

Cold sores

Cosmetic surgery

Tattoos

Glaucoma

Artificial joints:

Fear of dentistry?

Do you have any disease, condition, or problem not listed? If yes, please explain:

_____

Women: Are you pregnant or might you be pregnant now? O Yes O No

Are you currently using birth control pills? O Yes O No

(Office use) ASA I II III IV

Mallampati I II III IV

Validation of Medical History:

I, the undersigned, have given the above information as correct and true.

Patient's Signature: _____ **Date**: _____

or the Responsible Party: _____ **Relationship to Patient:** _____

Ver. 6/18

Medical History Update: Date ______________

O I have reviewed my medical history and there are absolutely no changes.
O I have reviewed my medical history and noted the necessary changes.

Patient's Signature: ______________________________ **Date** ______________

Medical History Update: Date ______________

O I have reviewed my medical history and there are absolutely no changes.
O I have reviewed my medical history and noted the necessary changes.

Patient's Signature: ______________________________ **Date** ______________

Medical History Update: Date ______________

O I have reviewed my medical history and there are absolutely no changes.
O I have reviewed my medical history and noted the necessary changes.

Patient's Signature: ______________________________ **Date** ______________

Medical History Update: Date ______________

O I have reviewed my medical history and there are absolutely no changes.
O I have reviewed my medical history and noted the necessary changes.

Patient's Signature: ______________________________ **Date** ______________

Medical History Update: Date ______________

O I have reviewed my medical history and there are absolutely no changes.
O I have reviewed my medical history and noted the necessary changes.

Patient's Signature: ______________________________ **Date** ______________

Medical History Update: Date ______________

O I have reviewed my medical history and there are absolutely no changes.
O I have reviewed my medical history and noted the necessary changes.

Patient's Signature: ______________________________ **Date** ______________

Medical History Update: Date ______________

O I have reviewed my medical history and there are absolutely no changes.
O I have reviewed my medical history and noted the necessary changes.

Patient's Signature: ______________________________ **Date** ______________

Medical History Update: Date ______________

O I have reviewed my medical history and there are absolutely no changes.
O I have reviewed my medical history and noted the necessary changes.

Patient's Signature: ______________________________ **Date** ______________

Medical History Update: Date ______________

O I have reviewed my medical history and there are absolutely no changes.
O I have reviewed my medical history and noted the necessary changes.

Patient's Signature: ______________________________ **Date** ______________