Medical History

Name_____

Date of birth _____ Gender: _____

In the following questions, answer yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Do you currently have a physician? YES ❍ NO ❍

Are you being treated for a specific condition? _____ Date last physical_____

Physician's name _____ Dr. Phone #_____

Do you have or have you ever had?

Abnormal bleeding	❍Y ❍N	Kidney disease	❍Y ❍N	High blood pressure	❍Y ❍N
Alcoholism/drug addiction	❍Y ❍N	Liver disease/hepatitis A,B,C	❍Y ❍N	Previous stroke	❍Y ❍N
Anemia or blood disorders	❍Y ❍N	Osteoporosis	❍Y ❍N	Loud snoring	❍Y ❍N
Arthritis	❍Y ❍N	Radiation Therapy	❍Y ❍N	Daytime fatigue, tired	❍Y ❍N
Asthma	❍Y ❍N	Sinus condition	❍Y ❍N	Stop breathing during sleep.	❍Y ❍N
Cancer or tumor	❍Y ❍N	Stomach ulcers	❍Y ❍N	Restless Sleep	❍Y ❍N
Diabetes (HbAlc # :_____)	❍Y ❍N	Thyroid disease	❍Y ❍N	Clenching/grinding	❍Y ❍N
Epilepsy, seizures	❍Y ❍N	Angina (chest pain)	❍Y ❍N	GERD/acid reflux	❍Y ❍N
Fainting spells	❍Y ❍N	Heart attack/TIA	❍Y ❍N	Xerostomia (dry mouth)	❍Y ❍N
Glaucoma	❍Y ❍N	Heart surgery	❍Y ❍N	**Women:**	
Herpes or other STD	❍Y ❍N	Heart valve replacement	❍Y ❍N	Are you pregnant?	❍Y ❍N
HIV	❍Y ❍N	Pacemaker	❍Y ❍N	Taking birth control?	❍Y ❍N
Immune deficiency or lupus	❍Y ❍N	Rheumatic fever	❍Y ❍N	Are you nursing?	❍Y ❍N

Have you been diagnosed with sleep apnea? YES ❍ NO ❍ Do you wear a CPAP? YES ❍ NO ❍

Do you smoke or use other tobacco products? YES ❍ NO ❍ # per day _____ # of years _____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? YES ❍ NO ❍ Date _____

Have you been told you need antibiotics prior to a dental visit? YES ❍ NO ❍

Do you have any disease, condition or problem not listed above?

_____

_____

Are you taking any of the following?

Anticoagulants (blood thinners)	Y ❍ N ❍
Medicine for high blood pressure	Y ❍ N ❍
Cortisone or other steroids	Y ❍ N ❍
Aspirin	Y ❍ N ❍
Tranquilizers or antidepressants	Y ❍ N ❍
Diabetes medication	Y ❍ N ❍
Osteoporosis (bone density) drugs	Y ❍ N ❍
Nitroglycerin	Y ❍ N ❍

Allergic or reacted adversely to?

Local anesthetics	Y ❍ N ❍
Penicillin/Amoxicillin	Y ❍ N ❍
Barbiturates, sedatives or sleeping pills	Y ❍ N ❍
Sulfa	Y ❍ N ❍
Codeine or other narcotics	Y ❍ N ❍
Latex	Y ❍ N ❍
Other_____	
Other_____	

List **all medications** including any over-the-counter medications, dietary or herbal supplements: _____

_____

The above information that I have provided is true and correct to the best of my knowledge.

_____ _____

Patient Signature Date Doctor Signature Date

Comments: