MEDICAL HISTORY

Name: ____ Date of Birth: ______________

Emergency Contact: ________________________ Ph. __________________ Relationship: ______________

☐ Yes ☐ No Are you currently under the care of a physician or have you had any medical treatment of any kind in the past two years? ____

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☐ Yes ☐ No Have you been advised by a physician of the need for any type of treatment that has not been completed? Please describe. ____

☐ Yes ☐ No Do you use any tobacco product? Approx daily intake. ______________________________

☐ Yes ☐ No Are you pregnant? Anticipated delivery date. ______________________________

☐ Yes ☐ No Have you ever been advised by a physician that you need to premedicate for dental appointments?

Please List ALL medications below, Prescribed, Herbal & Supplements

Condition	Drug	Dosage & Frequency

Y	N	Allergies
☐	☐	Codeine
☐	☐	Latex
☐	☐	Penicillin
☐	☐	Sulfa
☐	☐	__________
☐	☐	__________
☐	☐	__________
☐	☐	__________

Preferred Pharmacy: ____

Do you have, have you had, or have you been treated for any of the following?

Yes	No	Hip/Joint Replace, Date: ___	Yes	No	History of Bisphosphonates	Yes	No	Osteoporosis
Yes	No	Heart Murmur	Yes	No	Hearing/Vision loss	Yes	No	Chronic Sinus
Yes	No	Rheumatic Fever	Yes	No	Diabetes	Yes	No	Arthritis
Yes	No	Cholesterol	Yes	No	Asthma	Yes	No	Kidney Disorder
Yes	No	Pacemaker	Yes	No	Allergies	Yes	No	Thyroid Condition
Yes	No	Artificial Heart Valve	Yes	No	Tuberculosis	Yes	No	Hepatitis
Yes	No	Congenital Heart Defect	Yes	No	Stroke	Yes	No	Ulcers
Yes	No	Heart Attack, Date:________	Yes	No	Anemia, Sickle Cell	Yes	No	Cancer
Yes	No	Other Heart Problems: _____	Yes	No	Bleeding or Blood Disorder	Yes	No	HIV or AIDS
Yes	No	GERD (Gastro Esophageal Reflux Disease)	Yes	No	Blood Transfusion	Yes	No	Anorexia, Bulimia
Yes	No	High Blood Pressure	Yes	No	Epilepsy, Seizures	Yes	No	Chemical Dependency
Yes	No	Low Blood Pressure	Yes	No	Anxiety/ Depression	Yes	No	Other: ______________

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE ______________________________________ DATE______________________