Medical History

PATIENT NAME: ______________________ **Birthdate:** __________

Primary Physician: ______________________ **Phone Number:** __________

Question	Y/N	
Are you currently under a doctor's care?	☐ Y ☐ N	If yes, please explain: ______
Have you been hospitalized or had any surgeries in the last 5 years?	☐ Y ☐ N	If yes, please explain: ______
Do you use tobacco products?	☐ Y ☐ N	Type/Day/How long? ______
Do you consume alcoholic beverages?	☐ Y ☐ N	How often? ______
Do you use recreational drugs?	☐ Y ☐ N	If yes, list type: ______
Have you had an unfavorable reaction following dental treatment?	☐ Y ☐ N	If yes, please explain: ______
Have you taken in the past 12 years, or are you currently taking, any bisphosphonate medications?	☐ Y ☐ N	If yes, how long and what type: ______
Are you taking any drugs, supplements, or medications?	☐ Y ☐ N	If yes, please explain:

Are you allergic to any of the following?

☐ Penicillin ☐ Codeine ☐ Tetracycline ☐ Erythromycin
☐ Sulfa Drugs ☐ Metals ☐ Latex ☐ Dental Anesthetics
☐ Other Please explain: ______________________

FEMALE: Are you

Pregnant? ☐ Y ☐ N **Nursing?** ☐ Y ☐ N **Taking oral contraceptives?** ☐ Y ☐ N

Do you have or have you experienced any of the following? Please check all that apply.

☐ Abnormal Bleeding	☐ Difficulty Breathing	☐ Kidney Disease	☐ Tuberculosis
☐ AIDS/HIV	☐ Digestive Disorder	☐ Liver Disease	☐ Ulcers/GERD
☐ Alcohol Addiction	☐ Drug Addiction	☐ Neurological Disorder	
☐ Alzheimer's or Dementia	☐ Emphysema	☐ Osteoporosis	
☐ Artificial Pins, Bones or Joints	☐ Epilepsy or Seizures	☐ Persistent Cough	HEART:
☐ Asthma	☐ Fainting	☐ Psychiatric Problems	☐ Arrythmia
☐ Blood Disease	☐ Glaucoma	☐ Radiation Therapy	☐ Artificial Heart Valve
☐ Blood Thinners	☐ Hay Fever	☐ Rheumatic Fever	☐ Chest Pains
☐ Blood Transfusion	☐ Headaches	☐ Scarlet Fever	☐ CHG
☐ Cancer/Tumors	☐ Hepatitis A	☐ Seizure Disorder	☐ Heart Attack
☐ Chemotherapy	☐ Hepatitis B	☐ Shingles	☐ Heart Disease
☐ Chicken Pox	☐ Hepatitis C	☐ Shortness of Breath	☐ Heart Murmur
☐ Cold Sores	☐ Herpes	☐ Sickle Cell Disease	☐ Heart Surgery
☐ Colitis	☐ High Blood Pressure	☐ STD	☐ Mitral Valve Prolapse
☐ Diabetes	☐ Hearing Problem	☐ Thyroid Disease	☐ Pacemaker
☐ Depression	☐ Hemophilia	☐ Tonsillitis	☐ Stoke/CVA

Please specify marked items and/or list any serious medical condition(s) not indicated above:

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Sleep Disorder Questionnaire:

Question	Y/N
Do you often feel tired, fatigued, or sleep during the day?	☐ Y ☐ N
Has any observed you stop breathing during your sleep?	☐ Y ☐ N
Do you snore loudly?	☐ Y ☐ N
Are you 50 years or older?	☐ Y ☐ N
Is your neck circumference greater than 16 inches?	☐ Y ☐ N

NOTE: Both doctor and patient are encouraged to discuss any and all relevant health issues prior to treatment. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to dental examination and any necessary records that are necessary for an accurate diagnosis. I authorize the dentist to use any treatment records, x-rays, models, or photos for scientific, teaching, or promotional purposes. By signing this form, I acknowledge that the information is true and accurate to the best of my knowledge.

Signature: ______________________ **Date:** __________

Print Name: ______________________ **Relationship to Patient:** __________