Medical History

Patient_____Preferred Name_____
Last First Initial

Address_____City_____State_____ZIP_____

Email_____ Birthdate_____ Age_____

SS#_____ Home Phone _____ Cell _____

Occupation_____ Employer _____Spouse Name_____

Emergency Contact Name_____ Phone _____

How did you hear about us? Website Facebook Other Family/Friend (Name) _____

Medical History: Have you ever had any of the following? (Check all boxes that apply.)

☐ Heart Problems	☐ Liver Disease (Hepatitis, Jaundice)	☐ Blood Disease
☐ Pacemaker	☐ Kidney Disease	☐ HIV / AIDS
☐ Mitral Valve Prolapse	☐ Tumor or Cancer	☐ Epilepsy, Seizures
☐ High Blood Pressure	☐ Chemotherapy	☐ Nickel Allergy
☐ Low Blood Pressure	☐ Radiation Treatment	☐ Chemical Dependency
☐ Artificial Heart Valve	☐ Circulatory Problems	☐ Psychiatric Care
☐ Artificial Joints	☐ Stroke	☐ General Allergies
☐ Asthma	☐ Diabetes	☐ Latex Allergy
☐ Respiratory Disease	☐ Immunosuppressive Disorders	☐ Ulcer, Colitis

Tobacco/ Nicotine User? ☐ No ☐ Yes

Are you taking any prescriptions **OR** over-the-counter medications? ☐ No ☐ Yes

Please list each one (name) _____

_____

Have you taken **OR** are you currently taking bisphosphonates (bone density medication)? ☐ No ☐ Yes

Have you been advised to take an antibiotic premedication prior to dental work? ☐ No ☐ Yes

Please list any drug/medication allergies _____

_____

List any serious medical condition(s)/surgeries you have ever experienced _____

_____

Women: Are you taking birth control pills? ☐ No ☐ Yes Do you suspect you are pregnant? ☐ No ☐ Yes

Are you nursing? ☐ No ☐ Yes

_____ _____

Patient Signature (Guardian if patient is under 18 years of age) ***Date***