# CONFIDENTIAL MEDICAL HISTORY

NAME ______________________________________________________________________________
(FIRST) (MIDDLE) (LAST)

PRIMARY DENTAL CONCERN OR PROBLEM? ____________________________________________
Have you ever had a bad dental experience? ______________________________________________
What is the date of your last dental visit? __________ Reason? ___________________________________
How did you hear about our office? _______________________________________________________
Are you happy with the appearance of your teeth? _________________________________________

FAMILY PHYSICIAN________________________________________PHONE__________________________
Are you under a physician's care? Yes No If yes, for what? (Be specific)_____________________________________
_______________________________________________________________________________
When was your last physical? _____________________________________________________________
Have you ever had a serious illness or major surgery? _______________________________________________
**Have you ever been advised to be <u>pre-medicated</u> prior to dental treatment?***___________________________________
**Have you ever used a bisphosphonate drug for osteoporosis or cancer treatment (ie. Fosamax, Aredia or Zometa)?* Yes No**
**(Women) Do you suspect that you are pregnant?* Yes No Are you nursing? Yes No**

**Have you ever had any of the following?** (check boxes that apply):

| | | |
|---|---|---|
| Angina & Carries Nitroglycerine* | Allergies to Latex* | High Blood Pressure * |
| Heart Disease* | Allergy to Amoxicillin / Penicillin/ Sulfa* | Low Blood Pressure with Fainting |
| Take Blood Thinners (Coumadin)* | Allergies to Anesthetics* | Hepatitis Type _____ |
| Heart Murmur | Metal (Nickel) Allergies* | Use/d Recreational Drugs |
| Mitral Valve Prolapse W/ Regurgitation | Asthma from Anxiety & Carries Nebulizer* | Chemical Dependency |
| Artificial Heart Valve or Joints | Diabetes Type_____* | Epilepsy / Seizure Disorder* |
| Rheumatic Heart Disease | Special Diet | Nervous Problems |
| A I D S/ HIV | Stroke | Tuberculosis |
| Respiratory Disease | MS | Fainting/ Dizzy Spells |
| Sinus Problems | Cancer | Migraines/ Neck Aches |
| Ulcer | Radiation Treatment | Venereal Disease |
| Arthritis | Blood Disease/ Bleeding Disorder | Taken PhenFen or Redux |
| Liver Disease | Anemia/ Leukemia | TMJ/ Painful Jaw Joint |
| Swollen Neck Glands | Mental Health Care | Use Tobacco/ Smoking |

**Is there anything else we should know about your medical history?** _________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
**Are you allergic to anything else?** ____________ Please list__________________________________________________

**Please list medications you are taking/ purpose:**
1. ____________________________/__________________________ 4. ____________________________/__________________________
2. ____________________________/__________________________ 5. ____________________________/__________________________
3. ____________________________/__________________________ 6. ____________________________/__________________________

**In case of emergency, please call**: ______________________________________ **Phone:** __________________________________

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

PATIENT/GUARDIAN SIGNATURE **X** _____________________________________________________ DATE _______________