Medical Health History Form

Legal Name of Patient ____ Birth Date ______/______/______ Title ___________
(FIRST) (MI) (LAST)

Gender Identity: M/F/Other (please specify): ______________________ Pronouns: He, Him, His / She, Her, Hers / They, Them, Theirs

Name of Spouse _________________________ E-Mail Address ____

Address ____ City ____________________ State ______ Zip ____________

Home Phone (______) _______-_________ Work Phone (______) _______-_________ Cell Phone (______) _______-__________

Who is your Primary Care Physician? ____ Phone ______________________

Other Treating Specialist ____ Phone ______________________

In case of emergency, whom should we contact? ______________________________________ Phone ______________________

Have you ever had any of these conditions? Check all that apply

- ❑ Pacemaker
- ❑ Stent or shunt
- ❑ Liver Disease
- ❑ Artificial or replacement valve
- ❑ Previous history of endocarditis
- ❑ High blood pressure
- ❑ Congenital heart defect with or without repair
- ❑ Artificial or replacement joints or pins
- ❑ Hepatitis *(circle one)* Type A Type B Type C
- ❑ **None of the above**

Are you allergic to or have you ever had an adverse reaction to any of the following? Check all that apply

- ❑ Penicillin
- ❑ Clindamycin
- ❑ Codeine
- ❑ Amoxicillin
- ❑ Cipro
- ❑ Aspirin
- ❑ Tetracycline
- ❑ Benzocaine
- ❑ Latex
- ❑ Azithyromycin (z-pack)
- ❑ Adhesive Tape
- ❑ NSAIDS (Advil, Celebrex)
- ❑ **None of the above**

Other____

Check any of the following that you currently have or have ever had

- ❑ Tuberculosis
- ❑ Type I Diabetes
- ❑ Asthma
- ❑ Cold sores
- ❑ Papilloma Virus
- ❑ Type II Diabetes
- ❑ Lung conditions
- ❑ HIV
- ❑ Herpes
- ❑ Anemia
- ❑ Canker sores
- ❑ Autoimmune disease (RA, Lupus, Sjogren's)
- ❑ Chemotherapy or radiation treatments
- ❑ Breathing or respiratory problems
- ❑ **None of the above**

Please answer yes or no to the following:

Yes No Do you routinely take antibiotic pre-medication prior to dental visits?
Yes No Are you allergic to latex?
Yes No Are you currently taking any blood thinners (such as Coumadin)?
Yes No Have you ever noticed that you clench or grind your teeth?
Yes No Do you snore?
Yes No Do you have sleep apnea?
Yes No Are you pregnant?
Yes No Are you taking birth control pills?
Yes No Do you have any food allergies? If yes, please list ____
Yes No Do you consume alcoholic beverages? If yes, how many drinks per week? ____________________________
Yes No Do you use tobacco? What form and how much? ____
Yes No Have you ever taken bisphosphonate drugs (such as Fosomax) if so, was it taken (*please circle*) orally by I.V.
What was the dosage? ___________ When did you start ____________ If you have stopped, when ____________
Yes No Have you ever had major surgery (organ transplant, open heart surgery, etc.)?
If yes, please explain ____

Do you have any other condition of which our office should be aware? If yes please explain

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Please list all medications (including dosage) that you are taking along with the reason for taking them ______________________

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To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Patient Signature ____ Date ________________________

Provider Signature ____ Date ________________________