

MEDICAL HISTORY

Patient Name: _____

Birth Date: _____

Are you in good health? ☐ Yes ☐ No Height _____ Weight _____ Are you under care of a physician? ☐ Yes ☐ NoAre you currently taking or planning to take antibiotics before dental treatment? ☐ Yes ☐ NoHave you been hospitalized in the past five years? ☐ Yes ☐ No Have you ever had general anesthesia? ☐ Yes ☐ NoHave you or your family had reactions to general anesthesia? ☐ Yes ☐ No Have you had the COMD vaccination? ☐ Yes ☐ NoAre you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Redast, Prolia, Xgeva, or Evista in the past 12 years? ☐ Yes ☐ No**WOMEN ONLY****1-4 below for women only:**

(Note: antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy? ☐ Yes ☐ No

2) Expected delivery date _____

3) Are you nursing? ☐ Yes ☐ No

4) Are you taking birth control pills? _____

☐ Yes ☐ No**ALLERGIES/REACTIONS**

YN	YN	YN	YN
☐ ☐ Penicillin	☐ ☐ Sulfa drugs	☐ ☐ Local anesthetic	☐ ☐ Amoxicillin
☐ ☐ Aspirin	☐ ☐ Codeine or other narcotics	☐ ☐ Latex	☐ ☐ Do you have any known allergies

Please list any allergies not listed above _____

MEDICAL CONDITIONS**Do you have, or have you had, any of the following diseases, medical conditions, or procedures?**

YN	YN	YN	YN
☐ ☐ AIDS / HIV	☐ ☐ Dementia	☐ ☐ High blood pressure	☐ ☐ Prosthetic implant
☐ ☐ Alzheimer's	☐ ☐ Diabetes	☐ ☐ High cholesterol	☐ ☐ History of Radiation
☐ ☐ Anemia	☐ ☐ Do you smoke or vape	☐ ☐ History of alcohol / drug abuse	☐ ☐ Respiratory problems
☐ ☐ Arthritis / Joint disease	Number of smoke/day _____	☐ ☐ History of marijuana / drug use	☐ ☐ Rheumatic fever
☐ ☐ Asthma	☐ ☐ Do you use chewing tobacco	☐ ☐ Infectious mononucleosis	☐ ☐ Sexually transmitted diseases
☐ ☐ Bleeding tendency	☐ ☐ Emphysema	☐ ☐ Irregular heart beat	☐ ☐ Sleep apnea / CPAP
☐ ☐ Blood transfusion	☐ ☐ Eye disease / Glaucoma	☐ ☐ Joint replacement	☐ ☐ Special diet
☐ ☐ Bronchitis	☐ ☐ Fainting spells	☐ ☐ Kidney trouble	☐ ☐ Stomach ulcers / acid reflux
☐ ☐ Bruise easily	☐ ☐ Hay fever / Sinus problems	☐ ☐ Liver disease	☐ ☐ Stroke
☐ ☐ Cancer	☐ ☐ Heart attack(s)	☐ ☐ Low blood pressure	☐ ☐ Thyroid trouble
☐ ☐ Chest pain / Angina	☐ ☐ Heart murmur	☐ ☐ Low blood sugar	☐ ☐ Trouble climbing 1-2 flights of stairs
☐ ☐ Chronic cough	☐ ☐ Heart pacemaker	☐ ☐ Mental health problems	☐ ☐ Tumor or growth
☐ ☐ Chronic fatigue / Night sweat	☐ ☐ Heart surgery	☐ ☐ Osteopenia	
☐ ☐ Convulsions / Epilepsy	☐ ☐ Heart trouble	☐ ☐ Osteoporosis	
☐ ☐ COVID-19	☐ ☐ Heart valve issues	☐ ☐ Pneumonia	
☐ ☐ Delay in healing	☐ ☐ Hepatitis	☐ ☐ Problems with immune system	

Any other medical conditions not listed above _____

MEDICATIONS**Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):**

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

PATIENT SIGNATURE

X

X

Signature of patient

Date

DOCTOR'S NOTES

X

X

Signature of dentist

Date