Patient:

Birth Date:
Record Date:

Medical Information

Emergency Contact:

Physician:

Reason for your visit?

Allergies:

Yes	No	Penicillin/Amoxicillin
Yes	No	Food/Preservatives/Sulfites
Yes	No	Latex
Yes	No	Bandages/Adhesives
Yes	No	Bleach
Yes	No	Local Anesthetics
Yes	No	Aspirin
Yes	No	Ibuprofen (Advil/Motrin)
Yes	No	Naproxen (Aleve)
Yes	No	Codeine/Other Pain Control
Yes	No	Sulfa
Yes	No	Any Other

Current Medications:

Yes	No	Antibiotic
Yes	No	Pain Medicine
Yes	No	Aspirin
Yes	No	Blood Thinners
Yes	No	Blood Pressure
Yes	No	Other Heart Meds
Yes	No	Bisphosphonates
Yes	No	Birth Control Pills
Yes	No	Any Other Medications
Yes	No	Insulin/Diabetes
Yes	No	Thyroid
Yes	No	Steroids
Yes	No	Chemotherapy
Yes	No	Antidepressants
Yes	No	Antianxiety
Yes	No	Other Psychiatric Meds
Yes	No	Asthma

Do you have to be premedicated with antibiotics for dental treatment: Yes No

List all Medications:

List of Allergy Issues:

Pharmacy Info:
Name:
Phone:
Address:

Medical Information – More

Do you currently have or have a history of the following conditions:

Heart Disease Yes No	Ulcers/Digestive Yes No	Any Transplant Yes No	Dry Mouth Yes No
Heart Murmur/Defect Yes No	Glaucoma Yes No	Joint Replacement Yes No	Clenching/Grinding Yes No
Heart Attack Yes No	Epilepsy/Seizures Yes No	Headaches Yes No	Jaw/TMJ Yes No
High Blood Pressure Yes No	Vertigo Yes No	Alcoholism/Addiction Yes No	Past Root Canal Yes No
Pacemaker Yes No	Cancer Yes No	Pregnant Yes No	Poor Dental Hygiene Yes No
Diabetes Yes No	Radiation/Chemo Yes No	Nursing Yes No	Thyroid Yes No
Immunocompromised Yes No	Sinusitis Yes No	Kidney Yes No	Autoimmune Disease Yes No
Arthritis Yes No	Blood Disorders Yes No	Infectious Disease Yes No	Any Other Condition Not Listed Yes No
Liver Yes No	Respiratory/Asthma Yes No		

The medical information I have provided here is complete. I do not hold any staff member in this office responsible for any errors or omissions that I may have made in the completion of this information.

_____ Date: _____ _____ Date: _____

Patient Signature *Doctor Signature*

Medical Updates: I have reviewed my Health History and confirm that it accurately states present conditions.

Date	Signature	Changes to Health History	Dentist Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____