Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Medical History

Provide a list of the medications you are currently taking: If you brought a list of medications check here ☐

_____ _____ _____ _____

_____ _____ _____ _____

Please check if you have had or currently have any of the following conditions:

- ☐ Abnormal/ Excessive Bleeding
- ☐ Acid Reflux
- ☐ Alzheimer's/ Dementia
- ☐ Anemia
- ☐ Anxiety/ Depression
- ☐ Artificial Bones/Joints
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Autism
- ☐ Blood Disease/ Disorder
- ☐ Breathing Issues
- ☐ Cancer Type:_____
- ☐ Chemotherapy/ Radiation
- ☐ Cholesterol Problems
- ☐ Cold Sores
- ☐ COPD
- ☐ Diabetes Type:_____
- ☐ Drug/Alcohol Abuse
- ☐ Endocarditis
- ☐ Fainting
- ☐ Gags Easily
- ☐ Glaucoma
- ☐ Head/Neck/Back Injury or Pain
- ☐ Hearing Disorders
- ☐ Heart problems: _____
- ☐ Hepatitis Type:_____
- ☐ High/Low Blood Pressure
- ☐ HIV/AIDS
- ☐ Hypoglycemia
- ☐ Immune Disorder
- ☐ Jaw Pain
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Lung Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Psychiatric Care
- ☐ Reclast IV
- ☐ Renal Dialysis
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism/ Arthritis/Gout
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Smoke/Chew/ Vape Tobacco
- ☐ Snoring
- ☐ STD Type:_____
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcer

Any additional medical conditions not listed? _____

Do you take a blood thinner? YES ☐ NO ☐ Do you take a daily aspirin? Dosage:_____

Do you take a PREMEDICATION prior to dental procedures? Why? _____

Have you had any recent surgeries or been hospitalized recently? When/Why?

_____

Are you under physician's care? Why? _____

Do you use any controlled substance? What/Why? _____

Are you pregnant/planning on becoming pregnant? YES ☐ NO ☐ Nursing? YES ☐ NO ☐ Birth Control? YES ☐ NO ☐

Please check if you have any of the following allergies:

- ☐ Acetaminophen (Tylenol)
- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Ibuprofen (Motrin)
- ☐ Iodine
- ☐ Latex Sensitivity
- ☐ Metals
- ☐ Nitrous Oxide
- ☐ Penicillin/Amoxicillin
- ☐ Sedatives
- ☐ Sulfa Drugs
- ☐ Valium
- ☐ Other:_____

Name:_____ Signature:_____ Date:_____