



PATIENT INFORMATION: MEDICAL AND DENTAL HISTORY

Today's Date: _____

Patient Name: _____ Date of Last Dental Visit: _____

[FOR OFFICE USE ONLY] - Medical and Dental History; Medications Review; Documentation Update(s):

1. [Patients]- List all medications, herbs, vitamins, and supplements taken and why:

2. [Patients]- List any allergies to substances; for example- drugs; latex; metals:

3. [Patients]- List the name and address of your Physician(s):

4. [Patients]- If a doctor has advised taking antibiotics before dental treatment, what antibiotic and why?

5. [Patients]- If taking drugs for Osteoporosis or high-blood calcium, what drugs, how long, and why?

6. [Patients]- If ever treated for Cancer with Radiation, Cobalt, and/or Cancer Chemotherapy, explain:

7. [Patients]- If taking medications to slow clotting or 'thin blood', what medications and why?

8. [Patients]- If you use tobacco and/or alcohol, please describe your personal use:

9. [WOMEN ONLY]- Do you use birth control pills? Could you be pregnant?

[Patients]- **CIRCLE** ANY CONCERNS BELOW RELEVANT TO YOU AND EXPLAIN:

High Blood Pressure / High Cholesterol / Heart Attack / Vascular Shunts or Grafts / Diet Pills- ex. Fen-Phen

Mitral Valve Prolapse or Other Murmur / Rheumatic Fever / Endocarditis / Pacemaker /Angina

Other Heart Disease / Stroke / Bloody Cough / Night Sweats / Diabetes / Liver Disease – ex. Hepatitis A, B, C

Hormone Replacement / Joint Replacement: hip-knee / Implants: Penile-Others / Organ Transplant

Tuberculosis / Kidney Disease / Depression / Seizures / Asthma / HIV – AIDS / Others Not Mentioned?

By signing this form, I consent to this Dental Office's use and disclosure of my records (or my child's records) to carry out treatment, obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to this dental office from my dental care insurance carrier or payor, agreeing that I am financially responsible for payment in full of all accounts. I certify that the above information is complete, accurate, and understood.

PATIENT'S / GUARDIAN'S SIGNATURE: _____

DATE: _____