**MEDICAL HISTORY**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL DOCTOR & OFFICE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**NONE**\_\_\_\_\_\_\_\_

**LATEX ALLERGY**? **Y**   **N** **PREMED REQUIRED?** **Y**  **N**   
**CURRENT MEDICATIONS:** (*Please list* ***ALL*** *prescriptions, supplements, and over the counter medications*)  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_See List\_\_\_\_\_\_\_  
**EMERGENCY CONTACT**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PHONE#**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CHECK ALL THAT APPLY** (Past ***and*** Current)   
\_\_\_\_\_ Currently under physicians care? \_\_\_\_\_ **Asthma**  
\_\_\_\_\_ Hospitalized/Operation last 5 yrs \_\_\_\_\_ Sleep Apnea  
\_\_\_\_\_ Women: Pregnant (Current) \_\_\_\_\_ Tuberculosis  
\_\_\_\_\_ Women: Nursing (Current) \_\_\_\_\_ Sinus Trouble - Chronic  
\_\_\_\_\_ Women: Oral Contraceptive \_\_\_\_\_ History of Cancer (SELF)  
\_\_\_\_\_ Heart trouble/disease/surgery \_\_\_\_\_ Radiation to Head/Neck  
\_\_\_\_\_ **Artificial Joints** \_\_\_\_\_ Chemotherapy  
\_\_\_\_\_ Heart murmur \_\_\_\_\_ Eating Disorder  
\_\_\_\_\_ Liver/Kidney Disease \_\_\_\_\_ Stomach Reflux or Ulcer  
\_\_\_\_\_ Mitral valve prolapse \_\_\_\_\_ Sjogren’s Disease  
\_\_\_\_\_ Thyroid Disease \_\_\_\_\_ Fibromyalgia  
\_\_\_\_\_ Artificial heart valves \_\_\_\_\_ Autoimmune or immune diseases  
\_\_\_\_\_ Pacemaker Type: \_\_\_\_\_\_\_  
\_\_\_\_\_ Indwelling defibrillator \_\_\_\_\_ Arthritis or Joint Disorder  
\_\_\_\_\_ **High blood pressure** Controlled? Y N \_\_\_\_\_ Diabetes:   
 BP: / Type: \_\_\_\_\_\_\_ Controlled? Y N   
\_\_\_\_\_ Angina \_\_\_\_\_ Depression Diagnosed? Y N \_\_\_\_\_ Frequent Headaches \_\_\_\_\_ Epilepsy/ Seizures   
\_\_\_\_\_ Stroke \_\_\_\_\_ Cerebral Palsy  
\_\_\_\_\_ Bleeding problems \_\_\_\_\_ Fainting/Dizziness  
\_\_\_\_\_ Hemophilia \_\_\_\_\_ Venereal Disease  
\_\_\_\_\_ Bone Density Treatment \_\_\_\_\_ AIDS/HIV  
\_\_\_\_\_ Leukemia \_\_\_\_\_ Alcohol or chemical dependency   
\_\_\_\_\_ Lung Disease \_\_\_\_\_ Hepatitis  
\_\_\_\_\_ Shortness of Breath Type:\_\_\_\_\_\_\_  
\_\_\_\_\_ Glaucoma \_\_\_\_\_ HPV \_\_\_\_\_ HPV Vaccine  
\_\_\_\_\_ Do you need assistance transferring \_\_\_\_\_ Recreational/Street Drugs?  
 to dental chair

**Smoker: Y N** # of years:\_\_\_\_\_\_ Attempts to quit:\_\_\_\_\_  
**Smokeless Tobacco:** **Y N**   
**Any Other Medical Concerns We Should Be Aware Of**: **YES** OR **NO**- If yes,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Any Chief Dental Concerns**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_