Medical History

Name: _____ **Date:** _____

Medical Doctor & Office: _____

Allergies: _____

Latex Allergy: **Y N** **Prescribed Antibiotic Premed Required from MD?** **Y N**

Current Medications: (Please list ***ALL*** prescriptions, supplements, and over the counter medications)

_____

_____

_____ **See List:** _____

Emergency Contact Name: _____ **ER Contact Phone #** _____

Please check *ALL* that apply: (Past *and* Current)

_____ Currently under physician's care?
_____ Hospitalized/Operation last 5 yrs
Info: _____
_____ Women: Pregnant (Current)
_____ Women: Nursing (Current)
_____ Women: Oral Contraceptive
_____ Heart trouble/disease/surgery
_____ **Artificial Joints**
Info: _____
_____ Heart murmur
_____ Liver/Kidney Disease
_____ Mitral valve prolapse
_____ Thyroid Disease
_____ Artificial heart valves
_____ Pacemaker
_____ **High blood pressure:**
Controlled? **Y N** BP: _____
_____ High Cholesterol
_____ Angina
_____ Frequent Headaches
_____ Stroke
_____ Bleeding problems/Blood Thinners
_____ Hemophilia
_____ Bone Density Treatment
_____ Leukemia
_____ Lung Disease
_____ Shortness of Breath
_____ Glaucoma
Do you need assistance transferring
_____ to dental chair?

_____ **Asthma**
_____ Sleep Apnea
_____ Tuberculosis
_____ Sinus Trouble - Chronic
_____ History of Cancer (SELF)
When/Type: _____
_____ Radiation to Head/Neck
_____ Chemotherapy
_____ Eating Disorder
_____ Stomach Reflux or Ulcer
_____ Sjogren's Disease
_____ Fibromyalgia
_____ Autoimmune or immune diseases
Type: _____
_____ Arthritis or Joint Disorder
_____ Diabetes:
Type: _____ Controlled? Y N

_____ Depression Diagnosed? Y N
_____ Epilepsy/ Seizures
_____ Cerebral Palsy
_____ Fainting/Dizziness
_____ Venereal Disease
_____ AIDS/HIV
_____ Alcohol or chemical dependency
_____ Hepatitis
Type:_____
_____ HPV
_____ HPV Vaccine
_____ Recreational/Street Drugs? Type:_____

Smoker: **Y N** # of years: _____
Vape: **Y N** # of years: _____
Smokeless Tobacco: **Y N** # of years: _____

> Attempts to quit: _____

Any Other Medical Concerns We Should Be Aware Of: **YES NO**

If Yes:_____

Dental Concerns: _____

SIGNATURE: _____