Medical History Form

Name:____

What brings you to our office today? __________________________________

Past **AND** Present Medical Conditions

- ☐ Anxiety
- ☐ Emphysema
- ☐ COPD
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Diabetes (Type I, Type II)
- ☐ Cancer ____________________
- ☐ Joint Replacements ______________
- ☐ Congenital Heart Defects
- ☐ Heart Valve Replacements or Stents
- ☐ Pacemaker
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ HIV/AIDS
- ☐ Hepatitis B/C

Have you ever been told you need to take antibiotics prior to dental procedures? Yes / No

Any medical conditions not listed above __________________________________

Current Medications (List **ALL** medications you are taking)

____

____

** Have you ever taken medications called bisphosphonates (ex. Fosamax, Boniva)? Yes / No

Allergies (List what you are allergic to **AND** the reaction)

____

Past Surgeries (List **ALL** surgeries you have had in the past)

____

Past Hospitalizations (List reasons you have gone to the ER or been admitted)

____

Physician Information (List **ALL** Doctors you are currently go to)

Name ______________________ Phone ____________________

Fax _____________________

Name ______________________ Phone ____________________

Fax _____________________