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