MEDICAL HISTORY FORM

PATIENT NAME: ____ Age: _______ Sex: _______ BMI: ______

Health conditions you may have or medications you may be taking could have an important interrelationship with the dental care you will be receiving at The Comfort Dentist. Thank you for answering the following questions.

Height: _________ Weight: __________

Have you ever had Cortisone Treatment?	○ Yes	○ No	
Do you have a diagnosis of sleep apnea?	○ Yes	○ No	
Any problem with dental injections?	○ Yes	○ No	If yes, please explain: ______________________
Have you ever taken Bisphophonates (Fosamax, Aredia, Zometa, Actonel, Bonia)?	○ Yes	○ No	If yes, which Bisphosphonate? ______________________
Do you smoke/use tobacco/chew?	○ Yes	○ No	How much?______________________ Do you want to quit? ○ Yes ○ No
Have you undergone surgery?	○ Yes	○ No	If yes, when? ______________________ What surgery? ______________________

FOR WOMEN:

Pregnant? ○ Yes ○ No How many weeks? ____ Are you nursing? ○ Yes ○ No Trying to get pregnant? ○ Yes ○ No Taking birth control? ○ Yes ○ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

☐ Local anesthetic ☐ Penicillin or other antibiotics ☐ Aspirin, Ibuprofen, Tylenol ☐ Codeine, Valium or other ☐ Latex or metals
☐ Other ____ ☐ None

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Abnormal Bleeding	○ Yes	○ No	Cancer-Chemotherapy	○ Yes	○ No
Anemia/Blood disorder	○ Yes	○ No	Radiation Therapy	○ Yes	○ No
Diabetes	○ Yes	○ No	Colitis	○ Yes	○ No
Sickle Cell Disease	○ Yes	○ No	Ulcers	○ Yes	○ No
Angina Pectoris	○ Yes	○ No	Epilepsy/Seizures	○ Yes	○ No
Congenital Heart Defect?	○ Yes	○ No	Fainting or Dizzy Spells	○ Yes	○ No
Congestive Heart?	○ Yes	○ No	Frequent Headaches	○ Yes	○ No
Heart Attack, Heart Surgery, Heart Stent?	○ Yes	○ No	Glaucoma	○ Yes	○ No
If yes, when? ______________			Hepatitis	○ Yes	○ No
Heart Murmur/Mitral Valve Prolapse?	○ Yes	○ No	Liver Disease	○ Yes	○ No
High Blood Pressure	○ Yes	○ No	Kidney Disease	○ Yes	○ No
Rheumatic Fever/Bacterial Endocarditis	○ Yes	○ No	Psychiatric, Emotional, Nerve Problems?	○ Yes	○ No
Stroke If yes, when?______________	○ Yes	○ No	Sexually Transmitted Disease	○ Yes	○ No
Asthma/Difficulty breathing	○ Yes	○ No	Fever Blisters	○ Yes	○ No
Emphysema/Respiratory Disease	○ Yes	○ No	HIV & AIDS	○ Yes	○ No
Hay Fever	○ Yes	○ No	Sinus Problems	○ Yes	○ No
Tuberculosis	○ Yes	○ No	Thyroid Problems	○ Yes	○ No
Arthritis	○ Yes	○ No	Drug Abuse	○ Yes	○ No
Hip/Joint Replacement If yes, when? ______________	○ Yes	○ No	Other? Please specify. ______________	○ Yes	○ No

Please list any disease, conditions or problem you feel we need to be aware of:
____
____
____
____

Please list any medications you are currently taking and dosage:
____
____
____
____

To the best of the patient's knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is patient's responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE: ______________

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