Comprehensive Family and Cosmetic Dentistry
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Name:_____ **Age:**_____ **Date:**_____

Although our dental team will primarily focus on your oral health needs, we also need to be aware of your overall health. Medical conditions that you may have, or medications that you may be taking could have an important interrelationship with the dental treatment you will be receiving. Thank you for thoroughly and honestly answering the following questions.

MEDICAL HISTORY

1. Are you in good health? ☐Y ☐N
2. Have there been any changes in your general health within the past year? ☐Y ☐N
3. Approximate date of last complete physical exam: _____
4. Are you currently under the care of a physician? ☐Y ☐N
5. Physicians name, address and phone number: _____ _____ _____ _____
6. Have you ever been hospitalized for any surgical operation or serious illness? ☐Y ☐N
   If yes, please explain: _____ _____
7. Are you now taking any medication, including non prescription medications? ☐Y ☐N
   If yes, please explain: _____ _____
8. Have you had a recent weight loss? ☐Y ☐N
9. Do you use tobacco products? ☐Y ☐N
10. Do you use alcohol? ☐Y ☐N
11. Do you use any other drugs? ☐Y ☐N

WOMEN ONLY

Are you pregnant? ☐Y ☐N
Are you nursing? ☐Y ☐N
Are you taking birth control pills? ☐Y ☐N

Are you allergic to or have you had a reaction to any of the following:

1. Local Anesthetic ☐Y ☐N
2. Penicillin or other antibiotics ☐Y ☐N
3. Sulfa Drugs ☐Y ☐N
4. Codeine or other narcotics ☐Y ☐N
5. Aspirin ☐Y ☐N
6. Latex ☐Y ☐N
7. Other_____

OFFICE USE

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

VITAL SIGNS:

BP: _____
Pulse: _____

CONTINUED ON BACK SIDE

MEDICAL HISTORY CONTINUED

Do you have or have you ever had the following:

☐Y ☐N rheumatic fever	☐Y ☐N lung problems	☐Y ☐N arthritis
☐Y ☐N rheumatic heart disease	☐Y ☐N breathing problems	☐Y ☐N rheumatism
☐Y ☐N scarlet fever	☐Y ☐N asthma	☐Y ☐N joint replacement
☐Y ☐N heart murmur	☐Y ☐N tuberculosis	☐Y ☐N cancer
☐Y ☐N mitral valve prolapse	☐Y ☐N hepatitis	☐Y ☐N leukemia
☐Y ☐N heart attack or Angina	☐Y ☐N jaundice	☐Y ☐N HIV +
☐Y ☐N pace maker/heart surgery	☐Y ☐N liver disease	☐Y ☐N fainting spells
☐Y ☐N high blood pressure	☐Y ☐N diabetes	☐Y ☐N epilepsy
☐Y ☐N low blood pressure	☐Y ☐N thyroid problems	☐Y ☐N sexually transmitted disease
☐Y ☐N anemia	☐Y ☐N kidney problems	☐Y ☐N glaucoma
☐Y ☐N stroke	☐Y ☐N stomach ulcer	☐Y ☐N dental implants

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

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

FOR COMPLETION BY THE DENTIST

SUMMARY OF MEDICAL HISTORY

_____
_____
_____
_____

MEDICAL HISTORY UPDATE

DATE	*COMMENTS*	*DR. INITIALS*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____