DENTISTRY
by April Detar

Medical History

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact: _____ Phone: _____ Relationship_____

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics (Dental)
- ☐ Metals or Jewelry
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Tetracycline
- ☐ Tylenol

Do you have any of the following medical conditions?

- ☐ Acid Reflux (GERD)
- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Back Problems
- ☐ Bacterial Endocarditis
- ☐ Bleeding (Abnormal/Excessive)
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain (Angina Pectoris)
- ☐ Circulatory Problems
- ☐ Colitis
- ☐ Cold Sores (Herpetic Lesions)
- ☐ Congenital Heart Defect
- ☐ Cortisone Treatment/Medicine
- ☐ Cough (Persistent/Body)
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Difficulty Breathing/ Easily Winded
- ☐ Emphysema
- ☐ Enlarged Lymph Nodes
- ☐ Epilepsy or Seizures
- ☐ Fainting/ Dizziness
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches (frequent)
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Hemophilia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Problems (Renal Disease)
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lyme Disease
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Slow Healing Mouth Wounds
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disorder
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsilitis
- ☐ Tobacco or Vape Use
- ☐ Tuberculosis
- ☐ Tumors (Head/Neck)
- ☐ Ulcers
- ☐ Venereal Infection
- ☐ Weight Loss (unexplained)

HOSPITALIZATIONS & SURGERIES

Have you ever been hospitalized or had ANY surgical operations? ☐ Yes ☐ No

_____

_____

_____

_____

_____

ALCOHOL & SUBSTANCES

	Yes	No
Do you use controlled substances?	☐	☐
Do you have an alcohol dependency?	☐	☐
Have you ever been, or are currently, under treatment for chemical dependency or substance use disorder?	☐	☐

WOMEN: Are you

	Yes	No
Pregnant/ Trying to get pregnant?	☐	☐
Nursing?	☐	☐
Taking oral contraceptive or have a contraceptive implant	☐	☐

_____ _____

Signature Today's Date