Time 11:24 AM | Craig R Smith, DDS | Date 11/15/2017

Medical History Form

Patient Name: Birth Date: Date Created:

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following.

Question	Answer	If yes
Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had an artificial joint replacement?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you use recreational drugs?	○ Yes ○ No	If yes
Have you had the HPV vaccine?	○ Yes ○ No	
Do you drink alcohol? If yes, how many drinks per week?	○ Yes ○ No	If yes

Please list current medications, pills or drugs.

Do you...

☐ Smoke ☐ Chew ☐ Other

Are you...

☐ Pregnant / Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Adhesives			

Other allergies not listed above? ○ Yes ○ No If yes

Do you have, or have you had, any of the following?

☐ AIDS / HIV Positive	☐ Diabetes	☐ Recent Weight Change	☐ Alzheimer's Disease
☐ Drug Addiction	☐ Hepatitis B or C	☐ Anaphylaxis	☐ Easily Winded
☐ Herpes	☐ Rheumatic Fever	☐ Anemia	☐ Emphysema
☐ High Blood Pressure	☐ Angina	☐ Epilepsy or Seizures	☐ High Cholesterol
☐ Scarlet Fever	☐ Arthritis / Gout	☐ Excessive Bleeding	☐ Hives or Rash
☐ Shingles	☐ Asthma	☐ Fainting Spells or Dizziness	☐ Irregular Heartbeat
☐ Sinus Trouble	☐ Frequent Cough	☐ Kidney Problems	☐ Blood Transfusion
☐ Leukemia	☐ Stroke	☐ Breathing Problems	☐ Frequent Headaches
☐ Liver Disease	☐ Stomach / Intestinal Disease	☐ Bruise Easily	☐ Genital Herpes
☐ Low Blood Pressure	☐ Cancer	☐ Glaucoma	☐ Lung Disease
☐ Thyroid Disease	☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse
☐ Tonsillitis	☐ Chest Pains	☐ Heart Attack / Failure	☐ Osteoporosis
☐ Tuberculosis	☐ Cold Sores / Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints
☐ Tumors or Growths	☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Ulcers
☐ Convulsions	☐ Heart Trouble / Disease	☐ Psychiatric Care	☐ Hemophilia
☐ Radiation Treatments			

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Additional Comments

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

Signature of Patient, Parent or Guardian:

X Date:__________