**MEDICAL HISTORY**

Patient name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name/location of medical doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ifyou could change one thing about your smile, what would you change?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in whitening teeth? \_\_\_Y\_\_\_N Do you have trouble sleeping? \_\_\_Y\_\_\_N

Have you lost facial volume or have lines that you would like minimalized? \_\_\_Y\_\_\_N

Are you interested in replacing lost teeth with implants? \_\_\_Y\_\_\_N

Are you interested in straightening your teeth \_\_\_Y\_\_\_N Do you have face or jaw pain? \_\_\_Y\_\_\_N

Does your physician have you take a premed before dental visits? \_\_\_Y\_\_\_N

Are you taking medications, pills, or drugs? \_\_\_Y\_\_\_N If yes, please list below or provide list to photocopy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take blood thinners, ex. Coumadin, Warfarin, Plavix, Effient? \_\_\_Y\_\_\_N

Are you currently or have in the past taken bisphophonates, ex. Boniva or Actonel?\_\_\_Y\_\_\_N

**Women:** Pregnant/Trying to get pregnant?\_\_\_Y\_\_\_N Taking oral contraceptives\_\_\_Y\_\_\_N Nursing\_\_\_Y\_\_\_N

**Do you have any allergies?** If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle the following conditions that apply:**

Alzheimer’s Disease Anaphylaxis Anemia

Arthritis/Gout Artificial Heart Valve Artificial Joint

Asthma Chemotherapy Cortisone Medicine

Diabetes Drug Addiction/Controlled Substances Emphysema

Epilepsy/Seizures Fainting Spells/Dizzy Frequent Headaches

Heart Trouble/Disease Hemophilia Hepatitis A, B or C

Herpes/Cold Sores High/Low Blood Pressure Hypoglycemia

Kidney Problems/Renal Dialysis Leukemia Liver Disease

Lung Disease Parathyroid Radiation Treatments

Rheumatism Sinus Trouble Stomach/Intestinal

Stroke Thyroid or Parathyroid Tobacco Use

Tumor/Growth Ulcer

Have you ever had any serious illness/conditions not listed? If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please turn over**

What pharmacy do you use?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location of pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If 18 years of age or younger what is height?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ weight?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 medications/medical status.**

Signature of Patient, Parent, Guardian**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_