Medical History

NAME:

Conditions: Please check all that apply

o Abnormal Bleeding o Alcohol Abuse o ADD/ADHD o Anemia o Angina Pectoris o Arthritis o Artificial Heart Valve o Asthma o Autism o Cancer Type: _____ Treatment: _____ o Chemotherapy o Colitis o Heart Defect o Development Delay Specify: _____	o Diabetes o Difficulty Breathing o Drug Abuse o Emphysema o Epilepsy o Fainting Spells o Fever Blisters o Frequent Headaches o Glaucoma o HIV/AIDS o Heart Attack Date: _____ o Heart Murmur o Heart Surgery o Hemophilia o Hepatitis A/B/C (circle) o High Blood Pressure o Joint Replacement Date: _____	o Kidney Problems o Liver Disease o Low Blood Pressure o Mitral Valve Prolapse o Pacemaker o Psychiatric Problems o Radiation Therapy o Rheumatic Fever o Seizures o STD o Sickle Cell Disease o Shingles o Sinus Issues o Sleep Apnea o Stroke Date: _____ o Thyroid Problems o Tuberculosis o Ulcers	Do you smoke or use tobacco? ___Yes ___No *If Female:* Are you taking Birth Control Pills? ___Yes ___No Are you pregnant? ____Yes ____No (If yes, # of weeks___) Are you nursing? ____Yes ____No	Allergies ☐Aspirin ☐Codeine ☐Dental Anesthetics ☐Erythromycin ☐Latex ☐Metals ☐Penicillin ☐Sulfa ☐Tetracycline Other _____ _____ –

MEDICATIONS

Are you taking any blood thinners as Coumadin, Warfarin, Rivaroxaban (Xarelto), Clopidogrel (Plavix), heparin or aspirin?

_____Yes _____No

If yes, what medication are you taking? _____

Are you taking any medications to treat osteoporosis or Paget's Disease? Some commonly-prescribed drugs include alendronate (Fosamax), risedronate (Actonel), ibandronate (Boniva), zolendronate (Reclast), and denosumab (Prolia)?

_____Yes _____No

If yes, what medication are you taking? _____

List all and any medications, herbs, vitamins you are taking:

_____ _____ _____ _____

_____ _____ _____ _____

Fill out the following information:

Has a physician or previous dentist recommended you take antibiotics prior to dental treatment? ___Yes ____No

If so, which antibiotic do you take?_____

Have you had any operations or been hospitalized in the past 2 years? ____Yes _____No

If so, explain: _____

Is there any condition concerning your health that the dentist should be told about? _____Yes _____No

If so, explain: _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary and advisable including the use of local anesthesia and other medications as indicated. I certify to the above statements regarding my medical condition.

_____ _____

Patient's/Guardian's Signature Date