DO NOT USE - Med History Updated 11/2020

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, cc

Please give the name, phone number, and relation of your emergency contact.	☐	If yes	
Please give the name of your primary care physician.	☐	If yes	
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes	
Has it been recommended that you take antibiotics prior to dental treatment?	○ Yes ○ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel, or any other bone-densifying drugs (oral or IV)?	○ Yes ○ No	If yes	
Do you smoke or use other forms of tobacco?	○ Yes ○ No	If yes	
Do you have a history of chemical dependency or currently use controlled substances?	○ Yes ○ No	If yes	

Women: Are you...

Pregnant/Trying to get pregnant? ○ Yes ○ No	Breast feeding? ○ Yes ○ No	Using prescription birth control? ○ Yes ○ No

Are you allergic to or unable to take any of the following?

☐ NO KNOWN ALLERGIES	☐ Food Allergy	☐ Metal or Acrylic	☐ Sulfa Drugs
☐ Codeine	☐ Latex	☐ Cephalosporins	☐ Local Anesthetics
☐ Penicillin/Amoxicillin	☐ Aspirin/Ibuprofen		

Other allergies: ☐ If yes

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

Acid Reflux/GERD/Heartburn ○ Yes ○ No	Breathing Problems ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Neurological Disorder ○ Yes ○ No
ADHD ○ Yes ○ No	Bruise Easily ○ Yes ○ No	Heart Disease ○ Yes ○ No	Osteoporosis ○ Yes ○ No
AIDS / HIV Positive ○ Yes ○ No	Cancer/Growth/Tumor ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Organ Transplant ○ Yes ○ No
Alzheimer's or Dementia ○ Yes ○ No	Chemotherapy ○ Yes ○ No	Heart Pacemaker or Defibrillator ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Cold Sores or Canker Sores ○ Yes ○ No	Hepatitis/Liver Disease ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Anemia (Low Iron) ○ Yes ○ No	Congenital Heart Disease ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Rheumatic Fever* ○ Yes ○ No
Angina or Chest Pain ○ Yes ○ No	Cortisone Medication ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Sinus Trouble/Surgery ○ Yes ○ No
Anorexia or Bulimia ○ Yes ○ No	Diabetes ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sleep Apnea/Snoring ○ Yes ○ No
Arthritis/Rheumatism/Gout ○ Yes ○ No	Dry Mouth ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Stomach/Intestinal Condition ○ Yes ○ No
Artificial Heart Valve* ○ Yes ○ No	Emphysema/COPD ○ Yes ○ No	Kidney Problems/Dialysis ○ Yes ○ No	Stroke ○ Yes ○ No
Artificial Joint* ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	Learning Disability ○ Yes ○ No	Thyroid or Parathyroid Problem ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting/Dizziness ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Autism ○ Yes ○ No	Headaches/Migraines ○ Yes ○ No	Mental Health Care ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Blood Disorder ○ Yes ○ No	Head or Neck Injury ○ Yes ○ No		

Have you ever had any illness or condition that is not listed above? ○ Yes ○ No If yes

Please explain YES answers from above.

Please list all prescription and over-the-counter MEDICATIONS as well as any VITAMINS or SUPPLEMENTS that you currently take.

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 Smile Design Dentistry of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____