

For Office Use Only

Medical Alert Yes – No	Pre-Medication Yes - No	Allergies Yes - No	Date ____/____/____
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Patient Medical History Form

Patient Name: _____ Date of Birth: ____/____/____ Sex: M F

Do you have a primary care physician? Y N Physician's Phone: _(____)_____

Primary Physician's Name: _____

Are you taking any medications? Yes No

If "yes," please list all of your medications in the boxes below, or provide us a list to include in your record:

<p>Have you had an allergic reaction to:</p> <p>Local anesthetic <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Codeine/other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturates/sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Metals <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other (Please specify): _____</p>	<p>For Women Only</p> <p>Are you:</p> <p>Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nursing <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
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Has a physician recommended that you take antibiotics prior to your dental treatment? Yes No

If "yes" please list the physician: _____

Has there been any change in your general health in the last year? Yes No

If "yes," please explain: _____

Have you taken, are you taking, or are you scheduled to begin taking a bisphosphonate medication (oral or I.V.)? Yes No

Please check a response to indicate you have or have not had any of the following diseases or medical problems:

	Yes	No		Yes	No
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice/Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Lupus (SLE)	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia/Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
GERD/heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve replacement	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any disease, condition, or problem not listed above that you think your dentist should know about?

Yes **No**

If "yes" please specify: _____

I certify that I have read and understand all of the information on this Patient Medical History Form. I acknowledge that my questions, if any, about inquiries set forth herein have been answered to my satisfaction. I will not hold my dentist, or any other member of Resnick, Tetelman, Young & Loeffel, DDS INC. responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient or Legal Guardian: _____ **Date:** ___/___/___

Doctor's Notes: _____

