For Office Use Only			
Medical Alert	**Pre-Medication**	**Allergies**	**Date**
Yes – No	Yes - No	Yes - No	___/___/___

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:

Have you had an allergic reaction to:

	Yes	No
Local anesthetic	☐	☐
Penicillin	☐	☐
Sulfa Drugs	☐	☐
Codeine/other narcotics	☐	☐
Barbiturates/sedatives	☐	☐
Latex	☐	☐
Metals	☐	☐

Other (Please specify): _____

For Women Only Are you:

	Yes	No
Pregnant	☐	☐
Nursing	☐	☐

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	☐	☐	Hepatitis/Jaundice/Liver disease	☐	☐
Anemia	☐	☐	Incontinence	☐	☐
Arthritis	☐	☐	Joint replacement	☐	☐
Asthma	☐	☐	Kidney Disease	☐	☐
Cancer	☐	☐	Lupus (SLE)	☐	☐
Chest Pain/Angina	☐	☐	Neurological disorder	☐	☐
Chronic pain	☐	☐	Osteopenia/Osteoporosis	☐	☐
Diabetes	☐	☐	Respiratory disease	☐	☐
Eating disorder	☐	☐	Migraines	☐	☐
Epilepsy	☐	☐	Pacemaker	☐	☐
Fainting spells	☐	☐	Sinus problems	☐	☐
GERD/heartburn	☐	☐	Sleep disorder	☐	☐
Glaucoma	☐	☐	Stroke	☐	☐
Heart attack	☐	☐	Thyroid dysfunction	☐	☐
Heart valve replacement	☐	☐	Tobacco use	☐	☐
High blood pressure	☐	☐	Tuberculosis	☐	☐

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: _____
_____
_____
_____