Patient Name Date of Birth _____

_____
FIRST LAST

Physician's Name: _____
City: _____ State: _____
Phone: _____

☐ **MALE** ☐ **FEMALE**

**When was your last complete physical exam?** _____

**Are you taking any medication or substances?** ☐ **YES** ☐ **NO** **(If yes, please print a list of medications in the box below.)**

| **Are You Allergic To...?** | ☐ **Medications** | ☐ **Antibiotics** |
|---|---|---|
| | ☐ **Substances** | ☐ **Latex** |

**Explanation:**

| **Are You Currently…?** | ☐ **Pregnant** | ☐ **Suspect To Be Pregnant** |
|---|---|---|
| | ☐ **Using Birth Control** | ☐ **Taking Bisphosphonates (for bone loss, osteoporosis, etc.)** |

**PLEASE CHECK ALL OF THE CONDITIONS BELOW THAT APPLY TO YOU**

☐ **Pacemaker**
☐ **Heart Disease**
☐ **Rheumatic Fever**
☐ **Low Blood Pressure**
☐ **Artificial Heart Valve**
☐ **Heart Murmurs**
☐ **High Blood Pressure**
☐ **Blood Disorders**

**Explanation:** _____

☐ **Artificial Joints/Prosthesis**
☐ **Arthritis**
☐ **Rheumatism**
☐ **Excessive Bleeding**
☐ **Stomach Problems**
☐ **Kidney Problems**

**Explanation:** _____

☐ **Asthma**
☐ **Epilepsy**
☐ **Seizures**
☐ **Diabetes Type _____**
☐ **Hepatitis A B C**
☐ **HIV / AIDS**
☐ **Tuberculosis**
☐ **Liver Problems**

**Explanation:** _____

**Notes/Medications**

**Have you ever had radiation or chemo treatment for a tumor, growth, cancer or other condition.** **Yes or No – Please explain** _____

**Please list additional conditions:**

***I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE***

**PATIENT/GUARDIAN'S SIGNATURE** _____ **DATE** _____

**DENTIST'S SIGNATURE** _____ **DATE** _____

**ANESTHETIC**

# MEDICAL HISTORY

**MEDICAL ALERT**