



2013 Patient Medical History Form

Name: _____ Date: _____

Occupation: _____ Birthdate: _____

Reason for today's visit: _____

Are you allergic to any medications? Yes No

If yes, please list: _____

Have you ever had a reaction to dental or local anesthesia (novocaine)?

Yes No If yes, describe the reaction: _____

Do you take antibiotics before you go to the dentist?

Yes No If yes, why: _____

Do you have a pacemaker or implanted defibrillator? Yes No

If female are you pregnant or nursing? Yes No

Do you smoke? Yes No Do you drink alcohol? Yes No How much? _____

List all medications and topicals that you use regularly, including prescriptions, over the counter meds, Vitamins and herbal supplements: _____

Do you now have, or have you ever had the following diseases or conditions? (Yes or no)

Skin Cancer Yes No If yes, list: _____

Family history of skin cancer Yes No If yes, list: _____

Specific skin conditions Yes No If yes, list: _____

Cold sores Yes No If yes, list: _____

Do you have any of these health conditions:

High Blood Pressure Yes No Emphysema Yes No

History of Heart Attack Yes No Asthma Yes No

Coronary Artery Disease Yes No Chronic Cough Yes No

Undiagnosed Chest Pain Yes No Heart Murmur Yes No

Shortness of Breath Yes No Wheezing Yes No

Irregular Heartbeat Yes No Stroke Yes No

Artificial Heart Valve Yes No High Cholesterol Yes No

Peripheral Vascular Disease Yes No Thyroid Disease Yes No

Congestive Heart Failure Yes No Seasonal Allergies Yes No

Diabetes Yes No Bleeding/Clotting Disorder Yes No

Kidney Disease Yes No Varicose Veins Yes No

Cancer Yes No Gastrointestinal Disease Yes No

Epilepsy/Seizure Yes No Liver Disease/Hepatitis Yes No

Arthritis Yes No Artificial Joints Yes No

Mental Illness Yes No HIV Yes No

List any other conditions/major surgeries: _____

Completed by: Patient Family Member (Read and Reviewed with the Patient)

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____