Medical Dental History Form

Name: _____

Name of Drug	Strength MG	Frequency Taken	Medication Taken for?
Have you ever taken medication containing bisphosphonates?	**Yes**	**No**	

Allergies to Medications	
Name of the Drug	Reaction you had

Latex Allergy _____ Yes _____ No

Past and Current Medical Conditions: Circle all that apply

Under Physicians' care	Heart trouble	Rheumatic Fever
Hospitalization? Operations in last 5 years Details:	Heart Surgery: Explain	High Blood Pressure
	Stroke	
	Artificial Heart Valves	Artificial Joint
Women Pregnant Due Date: _____	Anemia	Pre-medication needed prior to dental treatment
Diabetes: Type Controlled by:	Tobacco Use: Smoke / Chew/ Vape If quit, What Year: _____	Lung disease
		Leukemia
Emphysema/ COPD	Shortness of Breath	Sleep Apnea C-Pap
Sinus Trouble	Kidney Disease	Cancer Type:_____ Date: _____
Dialysis	Chemotherapy Date:_____	Eating Disorder
Radiation Treatment to Head/ Neck	Autoimmune disease: Lupus, Pemphigus, Multiple Sclerosis, Other	Asthma Inhaler?
Stomach Trouble Reflux, Ulcer, GERD	Head/neck/mouth Injuries	Glaucoma

Arthritis or joint disorder	Headaches	Neurologic disease
Fainting / Dizziness	AIDS/HIV Positive	Thyroid Disorder
Depression/Anxiety	Other psychiatric disorders	Convulsions/ Epilepsy/ seizures
Cerebral palsy	Alcohol or chemical dependency	Blood Thinners

To the best of my knowledge, 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 the dental office of any
changes in medical status.

Signature: **Date:**