



MEDICAL HISTORY

Patient Name: _____

Physician's Name: _____ Date of Last Physical: _____

Medication List: (Please fill in below or bring a current medication list including vitamins and supplements to your appointment.)

Do you take blood thinners? Yes No

Have you ever been told to take antibiotics before dental treatment? Yes No

Do you have any drug allergies or have you ever had an adverse reaction to medication?

Yes No If yes, what? _____

Have you had any surgeries in the last 24 months? Yes No

If yes, what? _____

Have you ever responded adversely to medical or dental treatment? Yes No

Have you ever had the following? (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> AIDS | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Cancer (site) _____ | |

Females: Are you pregnant? Yes No

Nursing? Yes No

Use Birth Control? Yes No

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold Saving Smiles Dentistry responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____

Date: _____