MEDICAL HISTORY...

Patient Name _____

Are you in good health? ❑ Yes ❑ No • Height _____ Weight _____ • Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Have you ever had general anesthesia or IV sedation? ❑ Yes ❑ No

Have you, or a family member, had any unusual or serious reactions to general anesthesia or IV sedation? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y N
- ❑ ❑ Rheumatic fever
- ❑ ❑ High blood pressure
- ❑ ❑ Low blood pressure
- ❑ ❑ Mitral valve prolapse
- ❑ ❑ Heart murmur
- ❑ ❑ Chest pain / Angina
- ❑ ❑ Heart attack(s)
- ❑ ❑ Irregular heart beat
- ❑ ❑ Cardiac pacemaker
- ❑ ❑ Heart surgery
- ❑ ❑ Damaged heart valves
- ❑ ❑ Pneumonia / Bronchitis / Chronic cough
- ❑ ❑ Chronic fatigue / Night sweat
- ❑ ❑ Trouble climbing 1-2 flights of stairs
- ❑ ❑ Anemia
- ❑ ❑ Asthma
- ❑ ❑ Mental health problems

Y N
- ❑ ❑ Problems with immune system *(possibly from med. / surg.)*
- ❑ ❑ Delay in healing
- ❑ ❑ Hay fever / Sinus problems
- ❑ ❑ Snoring
- ❑ ❑ Sleep apnea / CPAP
- ❑ ❑ Respiratory problems
- ❑ ❑ Tuberculosis
- ❑ ❑ Emphysema
- ❑ ❑ Do you smoke or vape? *If so, how much a day* _____
- ❑ ❑ Do you use chewing tobacco
- ❑ ❑ Is there a history / treatment for an alcohol use disorder
- ❑ ❑ Is there a history / treatment for a marijuana or substance use disorder?

Y N
- ❑ ❑ Abnormal bleeding
- ❑ ❑ Bleeding tendency
- ❑ ❑ Blood transfusion
- ❑ ❑ Blood disorder
- ❑ ❑ Bruise easily
- ❑ ❑ Eye disease / Glaucoma
- ❑ ❑ Jaundice / Liver disease
- ❑ ❑ Hepatitis
- ❑ ❑ Gallbladder trouble
- ❑ ❑ Fainting spells
- ❑ ❑ Convulsions / Epilepsy
- ❑ ❑ Stroke
- ❑ ❑ Thyroid trouble
- ❑ ❑ Diabetes
- ❑ ❑ Low blood sugar
- ❑ ❑ Are you on dialysis
- ❑ ❑ Kidney trouble

Y N
- ❑ ❑ Sexually transmitted diseases
- ❑ ❑ COVID–19
- ❑ ❑ Contagious diseases
- ❑ ❑ Infectious mononucleosis
- ❑ ❑ Swollen ankles
- ❑ ❑ Arthritis / Joint disease
- ❑ ❑ Prosthetic implant
- ❑ ❑ Joint replacement
- ❑ ❑ Osteoporosis / Osteopenia
- ❑ ❑ Osteonecrosis
- ❑ ❑ Stomach ulcers / Acid reflux
- ❑ ❑ GI troubles / IBS / Colitis
- ❑ ❑ Tumor or growth
- ❑ ❑ Cancer / Radiation / Chemotherapy
- ❑ ❑ Are you on a diet
- ❑ ❑ Contact lenses

MEDICATION & ALLERGIES...

Are you now taking:

Y N
- ❑ ❑ Nerve pills
- ❑ ❑ Diet pills

Y N
- ❑ ❑ Pain killers (including aspirin)
- ❑ ❑ Tranquilizers

Y N
- ❑ ❑ Muscle relaxers
- ❑ ❑ Insulin

Y N
- ❑ ❑ Stimulants
- ❑ ❑ Antidepressants
- ❑ ❑ Blood thinners (Coumadin, Aspirin, Eliquis, Xarelto)
- ❑ ❑ Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years?

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y N
- ❑ ❑ Penicillin
- ❑ ❑ Sodium pentothal / Valium / other tranq.
- ❑ ❑ Soy

Y N
- ❑ ❑ Sulfa drugs
- ❑ ❑ Aspirin
- ❑ ❑ Eggs / Yolk

Y N
- ❑ ❑ Local anesthetic (numbing med)
- ❑ ❑ Codeine or other narcotics
- ❑ ❑ Sulfites

Y N
- ❑ ❑ Amoxicillin
- ❑ ❑ Latex
- ❑ ❑ Do you have any known allergies

Please list any other medication or antibiotic you are allergic to:

MEDICATION / ANTIBIOTIC NAME	MEDICATION / ANTIBIOTIC NAME

Please list any allergies other than drug allergies:

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No