NOLES
FAMILY DENTISTRY

MEDICAL HISTORY for Patient Name: _____
First Middle Last

Patient DOB: _____ Patient SS#: _____

1.	Are you under the care of a physician now?	Yes	No
2.	Have you had any hospitalizations or operations?	Yes	No
3.	Have you had any major head or neck injury?	Yes	No
4.	Do you require antibiotic premedication for dental visits?	Yes	No
5.	Are you interested in being sedated for your dental visit?	Yes	No
6.	Do you have sleep apnea or problems with snoring?	Yes	No
7.	Do you use tobacco? If so, what kind and how often? _____	Yes	No
8.	Do you see a doctor for pain management? If so, who? _____	Yes	No
9.	Have you ever taken drugs for osteoporosis? (Fosamax; Boniva; Actonel; Reclast; Prolia)	Yes	No
10.	Are you taking any medications, supplements, pills, or controlled substances?	Yes	No

Medication List: _____

_____

Are you **allergic** to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Latex ☐ Sulfa Drugs
☐ Other _____

Do you have, or have you had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemo/Radiation
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Coughing
- ☐ Frequent Headaches
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Other(s) Not Listed:

_____
_____
_____

Women: Are you… ☐ Pregnant? If so, how far along are you? _____ ☐ Nursing? ☐ Taking Oral Contraceptives?

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. **I also understand that payment is due at time of service. If insurance does not pay, I know the balance is my responsibility. **

Signature of patient, parent, or guardian: _____