Medical History

Conditions: Please check all that apply

- o Abnormal Bleeding
- o Alcohol Abuse
- o ADD/ADHD
- o Anemia
- o Angina Pectoris
- o Arthritis
- o Artificial Heart Valve
- o Asthma
- o Autism
- o Cancer
  Type:_____

  Treatment:_____
- o Chemotherapy
- o Colitis
- o Heart Defect
- o Developmental Delay

  Specify:_____
- o Diabetes
- o Difficulty Breathing
- o Drug Abuse
- o Emphysema
- o Epilepsy
- o Fainting Spells
- o Fever Blisters
- o Frequent Headaches
- o Glaucoma
- o HIV/AIDS
- o Heart Attack
  Date:_____
- o Heart Murmur
- o Heart Surgery
- o Hemophilia
- o Hepatitis A/B/C (circle)
- o High Blood Pressure
- o Joint Replacement
  Date:_____
- o Kidney Problems
- o Liver Disease
- o Low Blood Pressure
- o Mitral Valve Prolapse
- o Pace Maker
- o Psychiatric Problems
- o Radiation Therapy
- o Rheumatic Fever
- o Seizures
- o STD
- o Sickle Cell Disease
- o Shingles
- o Sinus Issues
- o Sleep Apnea
- o Stroke
  Date:_____
- o Thyroid Problems
- o Tuberculosis
- o Ulcers

Do you smoke or use Tobacco? ___Yes ___No

If Female:

Are you taking Birth Control Pills? ___Yes ___No

Are you pregnant? ___Yes ___No

If yes, # of weeks_____

Are you nursing? ___Yes ___No

MEDICATIONS

Are you taking any **blood thinners** such as Coumadin, Warfarin, rivaroxaban (Xarelto), Clopidogrel (Plavix), heparin or aspirin?

If yes, what medication are you taking?_____

Are you taking any medications to treat **osteoporosis** or Paget's Disease? Some commonly-prescribed drugs include: alendronate (Fosamax), risedronate (Actonel), ibandronate (Boniva), zolendronate (Reclast), and denosumab (Prolia)? _____Yes _____No

If yes, what medication are you taking?_____

List all and any medications, herbs, vitamins you are taking:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Fill out the following information:

Has a physician or previous dentist recommend you take antibiotics prior to dental treatment?__Yes ___No

- If so, which antibiotic do you take?_____

Have you had any operations or been hospitalized in the past 2 years? ___Yes ___No

- If so, explain: _____

Is there any condition concerning your health that the dentist should be told about? ___Yes ___No

- If so, explain: _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary and advisable including the use of local anesthesia and other medications as indicated. I certify to the above statements regarding my medical condition.

_____ _____

Patient's/Guardian's Signature **Date**