Medical History Form

South Waterfront Dental
Todd L. Beck, DMD

MEDICAL / PHYSICIAN INFORMATION

Patient name: _____ Preferred name: _____ Birth Date: _____
LAST FIRST MI

Are you currenty under a physician's care? ☐No ☐Yes
If yes please explain: _____
Physician name, practice, phone#: _____
Date of last complete physical exam: _____
History of serious head/neck injury? ☐No ☐Yes _____
Have you ever been hospitalized or had a major operation? ☐No ☐Yes _____
Do you have arftificial heart valves or prostheses? ☐No ☐Yes _____
Have you had history of endocarditis? ☐No ☐Yes _____
Do you have a pacemaker? ☐No ☐Yes _____
Do you have artificial joints (knee, hip, shoulder, elbow)? ☐No ☐Yes _____
Have you taken antibiotics prior to dental appointments? ☐No ☐Yes _____
Are you on a special diet? ☐No ☐Yes _____
Do you consume non-diet soda? ☐No ☐Yes _____
Do you use controlled substances? ☐No ☐Yes _____
Do you consume alcohol? ☐No ☐Yes _____
Do you use tobacco? ☐No ☐Yes _____
If yes, how often and in what form _____

Women please select all that apply: ☐ Pregnant/due date _____ ☐ Trying to get pregnant ☐ Taking contraceptives ☐ Nursing

Do you have or have you had any of these conditions?

☐ AIDS	☐ Emphysema	☐ High blood pressure	☐ Osteoporosis	☐ Sinus problems
☐ Anemia	☐ Epilepsy/Seizures	☐ HIV	☐ Parathyroid disease	☐ STDs/STIs
☐ Arthritis	☐ Excessive bleeding	☐ Hives	☐ Psychiatric treatment	☐ Stomach problems
☐ Asthma	☐ Fainting	☐ Irregular heartbeat	☐ Radiation treatment	☐ Stroke
☐ Blood disorders	☐ Glaucoma	☐ Kidney problems	☐ Renal dialysis	☐ Thyroid disease
☐ Breathing problem	☐ Heart attack	☐ Leukemia	☐ Rheumatic fever	☐ Tonsillitis
☐ Cancer	☐ Hemophilia	☐ Liver problems	☐ Rheumatism	☐ Tuberculosis
☐ Chemotherapy	☐ Hepatitis A	☐ Low blood pressure	☐ Scarlet fever	☐ Tumors/Growths
☐ Cold sores	☐ Hepatitis B/C	☐ Lung disease	☐ Shingles	
☐ Diabetes	☐ Herpes	☐ Mitral valve prolapse	☐ Sickle cell anemia	

ALLERGIES

Are you allergic or sensitive to any of the following? ☐No ☐Yes Select any/all that apply:

☐ Latex ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Codeine ☐ Plastic ☐ Acrylic ☐ Local Anesthetics ☐ Nickel ☐ Metals ☐ Other

Explain reaction or provide additional details: _____

MEDICATIONS, VITAMINS, SUPPLEMENTS, ETC

Are you taking any medications, vitamins, supplements, pills or drugs? ☐No ☐Yes *If you need more room, please attach your own list.*

Medication	Dosage	Date started	For what reason?

If more than five medications, please provide your own list or a list from your provider.

Supplements/Vitamins: _____

Have you ever taken
Boniva, Fosamax, Actonel or Reclast? ☐No ☐Yes

Patient/guardian signature indicates the above information is complete and accurate.

X _____	_____	_____	_____	
SIGNATURE	Patient/Guardian Signature	EFDA / RDH Review	Dentist Review	Date
X _____	_____	_____	_____	
ANNUAL REVIEW	Patient/Guardian Signature	EFDA / RDH Review	Dentist Review	Date
X _____	_____	_____	_____	
ANNUAL REVIEW	Patient/Guardian Signature	EFDA / RDH Review	Dentist Review	Date