Patient Name	Nickname	Age

MEDICAL HISTORY Please use an "X" to mark your answers to the following questions.

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

	Yes	No
Heart (Cardiac)		
Pacemaker	☐	☐
Artificial Heart Valve	☐	☐
Congenital Heart Disease	☐	☐
Congestive Heart Failure	☐	☐
Heart Attack (date _____)	☐	☐
Heart Murmur	☐	☐
Stroke (date _____)	☐	☐
High or Low Blood Pressure *(circle)*	☐	☐
Autoimmune/Blood (Circulatory)		
HIV/AIDS	☐	☐
Autoimmune Disease (lupus, RA, etc.)	☐	☐
Bleeding Disorder/Blood Thinners	☐	☐
Sickle Cell Disease	☐	☐

	Yes	No
Cancer	☐	☐
Type: _____		
Date of Diagnosis: _____		
Chemotherapy/Radiation/Surgery *(circle)*	☐	☐
Brain (Neurological)/Mental Health		
Anxiety	☐	☐
Depression	☐	☐
ADD/ADHD	☐	☐
Epilepsy or Seizures	☐	☐
Mental Health Disorders	☐	☐
Neurological Disorders	☐	☐
Fainting or Dizzy Spells	☐	☐
Vertigo	☐	☐

	Yes	No
Respiratory (Breathing)		
Asthma	☐	☐
Tuberculosis	☐	☐
Sinus Trouble	☐	☐
Other		
Artificial Joints	☐	☐
Diabetes (type _____, HbA1c _____)	☐	☐
GERD	☐	☐
Hepatitis (type _____)	☐	☐
Transplant (date _____)	☐	☐
Sleep Problems (sleep apnea, snoring)	☐	☐
High Cholesterol	☐	☐
Eating Disorders	☐	☐
Osteoporosis	☐	☐

Do you have any **disease, condition, or problem that is not listed here**? If so, please explain.

Have you had any **major illnesses, surgeries, or hospitalizations in the last 5 years**? If so, please explain.

MEDICATIONS & SUBSTANCES

	Yes	No
***Have you ever premedicated prior to a dental visit?**	☐	☐
If yes, for what? _____		
What did you take? _____		
Do you **smoke tobacco**?	☐	☐
If yes, how many cigarettes/cigars per day? _____		
If yes, how many years have you been smoking? _____		
Have you thought about quitting or have you quit before?	☐	☐
Do you **chew tobacco**?	☐	☐
Do you use **vaping products**?	☐	☐
Do you use any **recreational drugs**, including **marijuana**?	☐	☐
How many **alcoholic beverages** do you have per week? _____		
Are you taking **dietary supplements, vitamins, and/or probiotics**?	☐	☐
WOMEN ONLY: Are you		
Taking **birth control pills?**	☐	☐
Pregnant? If yes, number of weeks: _____ trimester: _____	☐	☐
Nursing?	☐	☐

List all **medications, supplements, vitamins, and/or probiotics** taken **within the last 2 years**.

DRUG	PURPOSE	DRUG	PURPOSE

Please list any known **allergies or adverse reactions to medications or substances**.

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.

Signature of Patient or Responsible Party _____ Date _____