Steven E. Smith DDS MAGD

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Medical History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

OFFICE COMMENTS

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Your Physician's name, address, & phone number:

Preferred Pharmacy name and address

Emergency Contact name, address, and phone number

Have you been under the care of a physician, admitted to a hospital or needed emergency care in the past 5 years? ◯ Yes ◯ No

If yes, give details below

Are you taking any prescription, non-prescription or homeopathic medications, drugs, pills, or vitamin supplements? ◯ Yes ◯ No

If yes, please list below

Have you taken oral or IV bisphosphonate therapy (fosamax, actonel, boniva, skelid, didronel, aredia, zometa, bonefos) for osteoporosis or cancer?

◯ Yes ◯ No

If yes, please list below

Are you aware of having an allergic or adverse reaction to any medication or substance? ◯ Yes ◯ No

If yes, please list below

_____

_____

_____

Have you ever been told you need antibiotic premedication prior to dental procedures? ◯ Yes ◯ No

If yes, please list reason and antibiotic recommended

_____

_____

_____

Do you use tobacco (smoking or chewing)? ◯ Yes ◯ No

Have you ever had complications following dental treatment? ◯ Yes ◯ No

WOMEN ONLY: Are you

☐ Pregnant ☐ Nursing ☐ Taking Birth Control Pills

Please indicate if you have experienced any of the following:

☐ AIDS/HIV	☐ Alcoholism	☐ Allergies	☐ Anemia
☐ Arthritis	☐ Artificial Joints	☐ ArtificialHeartValve	☐ Asthma
☐ Autoimmune Issues	☐ Bisphosphonates Use	☐ Bleeding Problems	☐ Bruise Easily
☐ Cancer	☐ Chest Pain	☐ Circulatory Problem	☐ COPD
☐ Diabetes	☐ Drug Abuse	☐ Epilepsy/Seizures	☐ Fainting/Dizziness
☐ GERD	☐ Glaucoma	☐ Head Injuries	☐ Headaches
☐ Heart Attack	☐ Heart Disease	☐ Heart Murmur	☐ Hemophilia
☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol	☐ Jaundice
☐ Kidney Disease	☐ Latex Allergy	☐ Liver Disease	☐ Mental Disorder
☐ Organ Transplant	☐ Osteoporosis	☐ Pacemaker	☐ Penicillin Allergy
☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problem	☐ Rheumatic Fever
☐ Sinus Problem	☐ Sleep Apnea	☐ STD	☐ Stomach Problem
☐ Stroke	☐ Thyroid Disorder	☐ Tuberculosis	☐ Ulcers

Do you have any other conditions, diseases, etc., not listed above that we should be aware of? ◯ Yes ◯ No

If yes, please list below

_____

_____

_____

Authorization

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health I will inform the office at my next dental appointment without fail. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.**

If other than self, what is your relationship to the patient _____

Patient Signature and Date:_____ Provider Signature and Date: _____ Response Date:_____