MEDICAL HISTORY

ELEVATE FAMILY DENTISTRY

PATIENT NAME: DATE OF BIRTH: TODAY'S DATE:

NAME OF PHYSICIAN: PHYSICIAN OFFICE #:

DATE OF LAST EXAM: REASON FOR VISIT:

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
1. Hospitalization for illness or injury? If yes, please explain and list dates: _____	☐	☐
_____		
2. Are you aware of any allergic or adverse reactions to any substances or medications (antibiotics, latex, codeine, etc.)? _____	☐	☐
3. Heart problems or cardiac stent? If yes, explain: _____	☐	☐
4. History of infective endocarditis? _____	☐	☐
5. Artificial heart valve or repaired heard defect? _____	☐	☐
6. Pacemaker or implantable defibrillator? _____	☐	☐
7. Joint replacement. If yes, list type(s) and date(s): _____	☐	☐
8. High blood pressure? Date of last reading: _____	☐	☐
9. Low blood pressure? Date of last reading: _____	☐	☐
10. High cholesterol or taking statin drugs? _____	☐	☐
11. Stroke? If yes, date(s): _____	☐	☐
12. Anemia or other blood disorder? _____	☐	☐
13. Bleeding disorder? (INR>3.5) Specify: _____	☐	☐
14. Pneumonia, emphysema, asthma, shortness of breath. If yes, explain: _____	☐	☐
15. Viral infections (cold sores, herpes, etc.). Specify: _____	☐	☐
16. Hepatitis (type): _____	☐	☐
17. HIV/AIDS: _____	☐	☐
18. Tuberculosis: _____	☐	☐
19. Rheumatic Fever: _____	☐	☐
20. Scarlet Fever: _____	☐	☐
21. Measles: _____	☐	☐
22. Kidney Disease: _____	☐	☐
23. Jaundice: _____	☐	☐
24. Thyroid, parathyroid, or calcium deficiency? Explain: _____	☐	☐

FOR FRONT OFFICE USE ONLY: DATE SCANNED: _____ INITIALS: _____

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	YES	NO
25. Breathing or sleep problems (snoring, sleep apnea): _____	☐	☐
26. Diabetes? If yes, circle Type I or II: _____	☐	☐
27. Stomach or duodenal cancer? _____	☐	☐
28. Digestive or eating disorder? _____	☐	☐
29. Osteoporosis/osteopenia? If yes, are you taking bisphosphonates? _____	☐	☐
30. Arthritis? _____	☐	☐
31. Autoimmune disease (Sjogren's, rheumatoid arthritis, lupus, scleroderma, etc.)? _____	☐	☐
32. Glaucoma? _____	☐	☐
33. Head or neck injuries? If yes, explain: _____	☐	☐
34. Epilepsy, convulsions (seizures)? _____	☐	☐
35. Radiation therapy? If yes, explain: _____	☐	☐
36. Alcohol use? If yes, how many per week (average): _____	☐	☐
37. Recreation drug use? If yes, specify drug and how often: _____	☐	☐
38. Cigarettes or vaping? If yes, specify which one and how often: _____	☐	☐
39. Chewing tobacco? If yes, how often: _____	☐	☐
FOR WOMEN:		
40. Are you taking birth control? _____	☐	☐
41. Are you currently pregnant? If yes, how far along: _____	☐	☐
PREMEDICATION		
42. Have you ever been informed by a doctor that you need to premedicate with antibiotics prior to dental appointments? If yes, please specify: _____	☐	☐
Do you have any current or impending medical treatment that may possibly affect your dental treatment? If yes, please explain: _____	☐	☐

List all medications, supplements and/or vitamins you are currently taking. Include dosage and frequency:

MEDICATION	PURPOSE	MEDICATION	PURPOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY CHANGES IN MEDICATIONS YOU MAY BE TAKING.

Patient or Guardian Signature: _____ **Date:** _____

If signing as guardian or for a minor, print name and relationship: _____

Doctor's Signature: _____ **Date:** _____

FOR FRONT OFFICE USE ONLY: DATE SCANNED: _____ INITIALS: _____