

Avery's Creek Family Dentistry

Medical History and Information

Patient Name _____ Date of Birth _____

Primary Medical Doctor _____ Phone number of Doctor _____

Please circle Yes (Y) or No (N) along with the date if you have or have ever had any of the following:

Y N Abnormal Bleeding	Y N Congestive Heart Failure	Y N Heart Attack	Y N Psychiatric Treatment
Y N Acid Reflux	Y N Convulsions	Y N Heart Disease	Y N Radiation Therapy
Y N Alcohol Use/Abuse	Y N Cortisone Medicine	Y N Heart Surgery	Y N Rheumatic Fever
Y N Alzheimer's Disease	Y N Diabetes I or II	Y N Heart Murmur	Y N Rheumatism
Y N Anaphylaxis	Y N Difficulty Breathing	Y N Hemophilia	Y N Seasonal Allergies
Y N Anemia	Y N Drug Use/Abuse	Y N Hepatitis A, B, or C	Y N Seizures
Y N Angina Pectoris	Y N Eating Disorder	Y N High Blood Pressure	Y N Sexually Transmitted Disease
Y N Arthritis	Y N Endocarditis	Y N HIV/AIDS	Y N Sickle Cell Disease
Y N Artificial Heart Valve	Y N Emphysema	Y N Hives/Rash	Y N Sinus Problems
Y N Blood Transfusion	Y N Epilepsy	Y N Joint Replacement	Y N Steroid Treatment
Y N Bruise Easily	Y N Facial Surgery	Y N Kidney Problems	Y N Stroke
Y N Cancer	Y N Fainting Spells	Y N Liver Disease	Y N Thyroid Disease
Y N Chemotherapy	Y N Frequent Headaches	Y N Organ Transplant	Y N Tobacco Use
Y N Chest Pain	Y N Glaucoma	Y N Mitral Valve Prolapse	Y N Tuberculosis
Y N Cold Sores/Fever Blisters	Y N Hay Fever	Y N Pace Maker	Y N Ulcers
Y N Congenital Heart Defect	Y N Infective Endocarditis	Y N Pain in Jaw Joints	Y N Unexplained Weight Loss

If you have had joint replacement was the joint replaced with metal, ceramic or plastic prosthetic? _____

When was the joint replacement surgery? _____

Any current or history of other condition not listed above: _____

Please list all current medications and dosages: (use additional page if needed)

Are you currently taking in blood thinning medications? (ie. Coumadin, Warfarin, Plavix, Aspirin...) _____

Are you currently or have you ever taken any bisphosphonates for osteoporosis? (ie Actonel, Boniva, Fosamax, Didronal, Risedronate, IV therapy...) If yes, please list name, dose, and date taken: _____

Are you allergic to any of the following? If yes, please check and explain reaction:

Aspirin **Latex** Iodine Metals Sulfa Drugs Benzodiazepines

Penicillin Cephalosporins Local Anesthetics Dyes **Amoxicillin**

Other Known Allergies (including to any to other medications):

Have you been hospitalized or had any major surgeries, please explain:

Female Patients: Are you pregnant or nursing? YES NO If yes, what is your due date? _____

I have answered the above health history questions truthfully and to the best of my knowledge. I understand this information is important in order to receive dental care in the safest possible manner.

Signature _____ Date _____

