STORY CITY DENTAL

PATIENT MEDICAL & DENTAL HISTORY

Patient Name

Medical Clinic

Date of Birth

Physician

Allergies

Antibiotic premedication required by physician

Any medications you **CAN'T TAKE**

Reason

Type

Dose

CURRENT MEDICATIONS: (prescription, over the counter, and herbal)

Medication	Dosage	Frequency

Medication	Dosage	Frequency

PAST AND CURRENT MEDICAL CONDITIONS: (mark all that apply)

Condition	Yes	No
Under a physician's care		
Hospitalization/operations in last 5 yrs?		
Head/neck/mouth injuries		
Women: pregnant		
Women: nursing		
Heart trouble/disease		
Rheumatic fever		
Heart murmur		
Mitral valve prolapse		
Heart surgery		
Artificial joints: When:		
Organ transplant: When:		
High blood pressure		
Stroke		
Hemophilia		
Anemia		
Leukemia		
COPD/Emphysema/Shortness of breath		
Radiation treatment to head/neck		
Asthma		
Sleep Apnea: Any devices used:		
Cancer Type: Diagnosed:		

Condition	Yes	No
Chemotherapy		
Stomach ulcers/Gerd/Acid reflux		
Kidney disease		
Dialysis		
Eating Disorder Type:		
Immunological disease		
Sjogrens disease		
Arthritis or joint disease		
Diabetes: Type: A1C:		
Headaches		
Epilepsy/seizures Type: Frequency:		
Cerebral Palsy		
Fainting/dizziness		
AIDS/HIV positive		
Chemical dependency		
Hepatitis: Type:		
Thyroid disease		
Glaucoma		
Sinus trouble		
Tuberculosis: Active or dormant?		
Tobacco: Packs per day:		

Please explain any YES answers:

Patient Name

Patient Signature

Date

Dentist Signature

Date