Thomas family dental associates

# Medical History

*Name: Last, First, MI* _____

Have you ever had any of the following medical conditions?

| | | | | |
|---|---|---|---|---|
| ❑ Aids/HIV Positive | ❑ Heart Disease | ❑ Dry Mouth/Xerostomia | ❑ Fainting | ❑ Heart Valve repair/replace |
| ❑ Alcohol Use | ❑ Heart Murmur | ❑ Recreational Drug Use | ❑ Gag Reflex | ❑ Visually Impaired |
| ❑ Anemia | ❑ TIA | ❑ Renal Dialysis | ❑ Glaucoma | ❑ Venereal Disease |
| ❑ Arthritis | ❑ Hemophilia | ❑ Respiratory Problems | ❑ Hay Fever | ❑ Ulcers |
| ❑ Artificial Joints | ❑ Hepatitis | ❑ Rheumatism | ❑ Head Injuries | ❑ Tumors or Growths |
| ❑ Aspirin Use | ❑ Herpes Simplex | ❑ Seasonal Allergies | ❑ Hearing Impaired | ❑ Tuberculosis |
| ❑ Asthma | ❑ High Blood Pressure | ❑ Seizures | ❑ Mental Disorders | ❑ Lyme Disease |
| ❑ Blood Disease | ❑ High Cholesterol | ❑ Sinus Problems | ❑ Multiple Sclerosis | ❑ Low Blood Pressure |
| ❑ Blood Thinner | ❑ Irregular Heartbeat | ❑ Sleep Apnea | ❑ Osteoporosis | ❑ Excessive Bleeding |
| ❑ Cancer | ❑ Jaundice | ❑ Stomach Problems | ❑ Pacemaker | ❑ Tobacco Use |
| ❑ Diabetes | ❑ Kidney Disease | ❑ Stroke | ❑ Parkinson Disease | ❑ Thyroid Disease |
| ❑ Dizziness | ❑ Liver Disease | ❑ Swollen Glands | ❑ Radiation Treatment | |

Do you have any other health concerns not listed above? ❑ Yes ❑ No

If Yes, please explain: _____

Please list any medications, pills or drugs you are currently taking: _____

_____

Are you allergic to any of the following? ❑ Food Dye ❑ Latex ❑ Aspirin ❑ Ibuprofen ❑ Mint Polish ❑ Sulfate ❑ Codeine ❑ Metal

❑ Peanuts/Nuts ❑ Acetaminophen ❑ Epinephrine ❑ Fruit ❑ Sodium Laureth ❑ Penicillin ❑ Sulfa Drugs ❑ Local/Topical Anesthetic

Do you have any other Allergies not listed above? ❑ Yes ❑ No

If Yes, please explain: _____

Are you taking or have you ever taken medications for osteoporosis? ❑ Yes ❑ No

Do you have a physician (medical doctor)? ❑ Yes ❑ No Doctors Name: _____

Have you been hospitalized or had a major surgery? ❑ Yes ❑ No Please Explain:_____

Do you use tobacco products? ❑ Yes ❑ No Do you use controlled substances? ❑ Yes ❑ No

Women: Are you pregnant or think you are pregnant? ❑ Yes ❑ No Women: Are you nursing? ❑ Yes ❑ No

Is there any other information we should know? ❑ Yes ❑ No

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Guardian Signature Date