Time 2:05 PM | Jennifer Stewart,DDS,LLC | Date 2/7/2022

Medical History Form for PRINTED PATIENT USE

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name and Phone Number

Have you been hospitalized or had a major operation?

Has there been a recent change to your health? If yes, please explain

Are you taking any medications, pills, or drugs? If yes, please list them

Are you currently using a particular pharmacy? If yes, please give their name and phone number

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates for Osteoporosis or Cancer?

Do you use tobacoo or any controlled substances? ◯ Yes ◯ No If yes

Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Amoxicillin	☐ Barbiturates/ Sleeping Pills	☐ Epinephrine	☐ Household Bleach
☐ Metals or Plastics	☐ Penicillin	☐ Tetracycline	☐ Antibiotics
☐ Clindamycin	☐ Erythromycin	☐ Ibuprophen	☐ Morphine
☐ Seasonal Allergies	☐ Valium	☐ Asprine	☐ Codeine/ Other Narcotics
☐ Food Allergy	☐ Iodine	☐ NSAID (Advil/Motrin)	☐ Sulfa Drugs
☐ Other	☐ Bactrim	☐ Environmental Allergies	☐ Gluten
☐ Latex or Rubber	☐ Nuts		

Other? ☐ If yes

Do you have, or have you had, any of the following?

☐ Changes Since Last Visit	☐ Arthritis	☐ Blood Sugar-Low	☐ Cholesterol-High
☐ Emphysema	☐ Leukemia	☐ Osteoporosis	☐ Any Known Concerns or Issues
☐ Arthritis-Rheumatoid	☐ Blood Thinners	☐ Chronic Pain	☐ Fainting Spells
☐ Liver Disease	☐ Pacemaker	☐ Abnormal Bleeding	☐ Asprin Daily
☐ Blood Transfusion	☐ Claustrophobia	☐ Fever Blisters	☐ Metal Pins/ Plates
☐ Persistent Swollen Glands	☐ ADHD/ADD	☐ Asthma	☐ Bronchitis
☐ Congenital Heart Defect	☐ Fibromyalgia	☐ Mental Health Concerns	☐ Premedicate
☐ AIDS/HIV Infection	☐ Autoimmune Disease	☐ Bulimia	☐ Congestive Heart Failure
☐ Frequently Dry Mouth/Sjogren	☐ Migraines	☐ Stomach Ulcers/ Colitis	☐ Alcohol/Drug Abuse
☐ Bells Palsy	☐ Cancer/Tumor Growth	☐ Damaged/Artificial Heart Valve	☐ Hives
☐ Mitral Valve Prolapse	☐ Stroke or TIA	☐ Alzheimer	☐ Bladder Trouble
☐ Cardiocascular Disease	☐ Diabetes Type 1	☐ Infections - Recurrent	☐ Mouth Ulcers
☐ Thyroid Problems	☐ Anemia	☐ Blood Clotting Problems	☐ Chemotherapy/Radiation
☐ Jaundice	☐ Neurological Disorders	☐ TMJ Problems	☐ Angina
☐ Blood Pressure- High	☐ Chest Pain Upon Exertion	☐ Difficulty Breathing	☐ Joint Replacement/Surgery
☐ Organ Transplant	☐ Tuberculosis	☐ Anorexia	☐ Chicken Pox
☐ Difficulty Healing	☐ Kidney Problems	☐ Glaucoma	

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

Signature of Patient, Parent or Guardian:

X Date:___________