Medical History Form

Last Name: _____ First Name: _____ Middle _____

Date of Birth:_____ Date of last physical exam:_____

Emergency Contact Name: _____ Phone Number: _____

Primary Physician Name:_____ Phone:_____

Please mark all the health conditions that apply to you below;

- ☐ Abnormal bleeding
- ☐ Acid Reflux (GERD/Heartburn)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune diseases
- ☐ Bacterial infections
- ☐ Blood disorders
- ☐ Cancer / Chemotherapy / Radiation
- ☐ Chronic respiratory diseases
- ☐ Clenching / Grinding
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive disorders
- ☐ Eating disorders
- ☐ Endocrine disorders
- ☐ Heart diseases
- ☐ Heart valve replacement
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Herpes Zoster/Shingles
- ☐ Immune system disorders
- ☐ Inflammatory conditions
- ☐ Jaw/Face Injury
- ☐ Joint Replacement
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mental health disorders
- ☐ Neurological conditions
- ☐ Osteoporosis
- ☐ Rheumatologic conditions
- ☐ Sinus trouble
- ☐ Severe headaches/migraines
- ☐ Skin disorders
- ☐ Sleep disorders
- ☐ Stress-related conditions
- ☐ Thyroid disorders
- ☐ TMJ disorders / Jaw pain

Please describe and list any recent **illnesses, medical event, and/or surgery** that is not listed above:

Please list any **allergies**:

Please list any **medications** that you are taking:

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NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____