Medical History

First Name: Last Name:

Family Physician:

Phone Number:

List allergies:

Do you have or had	Yes	No	List medications/conditions/substances/occurrence
High blood pressure			
Low blood pressure			
Pregnancy			
Stroke			
Blood thinners			
Diabetes			
Osteoporosis/Osteopenia			
Cancer			
Asthma			
Anemia/Blood disorders			
Prosthetic cardiac valves			
Cardiac valve repair			
Infective endocarditis			
Cardiac transplant			
Congenital heart disease			
High Cholesterol			
Epilepsy or Seizure			
Psychiatric treatment			
Hepatitis			
HIV/AIDS			
Tuberculosis			
Autoimmune disease			
Cigarettes or Marijuana			
Recreational drugs			
Surgeries & Hospitalizations			

Describe any other conditions, medications, impending surgery or treatment that may possibly affect your dental treatment:

Patient's/Guardian's signature: Date:

Dentist signature: Date: