

MEDICAL HISTORY FOR DENTAL PATIENTS

Welcome! Please fill out this form accurately so that we may provide you with the best possible care.

nt N	Name:				Date: _						
rgies:					Date o	f Birth:					
1)	Please give the name and phone number of your <b>medical</b> doctor										
2)	Date of last visit v	with medical doctor	<u> </u>								
	Are you taking ar				YES		NO				
5)	If YES, please g										
4)	Have you had an	reaction to a	tance?	YES	}	N					
5)	-	escribe: patient in the hospi <sup>r</sup> st	_	YES		NO					
	_										
	Are you currently taking any anticoagulants?										
7)	Please circle any sp	pecialists you see on a	a regular basi	is:							
		diology Homotolog	v Rheuma	tology l	Endoci	rinology	Other				
,		y diagnostic testing	or lab work							:o <u>yo</u>	
,	Have you had any Which of the follow Heart Surgery, Diseat Chest Pain / Anginatheart Pacemaker Heart Murmur Mitral Valve Prolaps	y diagnostic testing owing have you had se or Attack	or lab work  d before or h  Diet: Special Ulcers / Ston Diabetes Thyroid Prob Respiratory /	nave at p or Restric	present cted lems		All item  Hepa HIV Blee Sick Live	atitis A, F Positive ding Disc le Cell A	apply t B or C / AIDS order .nemia	o yo	
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13) Do you have any dental problems now?	ES NO
If YES, please describe:	
14) How long has it been since you saw a dentist and v	what treatment was done?
I understand the above information is necessary to provide me wi manner. I have answered all questions to the best of my knowledge. I will my health ormedication.	
Patient/Guardian Signature	Date
If not the patient, please state the:	
Relationship to Patient	
Interpreter's Name (if an interpreter is present)	
*Medical History will be verified in eClinical Works	