

## Medical History Form

### Patient Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

### Medical History

Please check if you have or have had any of the following:

Anemia / Blood disorders

Allergies (medications, latex)

Arthritis / Rheumatism

Heart murmur / Heart disease

Artificial heart valves

Heart attack / Stroke

Asthma / Respiratory disease

Hepatitis A, B, or C

Bleeding disorders / Hemophilia

High blood pressure

Blood thinners (e.g. Warfarin, Eliquis)

HIV / AIDS

Cancer / Chemotherapy / Radiation

Kidney disease

Chest pain / Angina

Liver disease

Congenital heart defect

Seizures / Epilepsy

Diabetes Type 1 or 2

Sickle cell disease

Emphysema / COPD

Thyroid conditions

Gastrointestinal disorders

Tuberculosis

# Quincy Dental

1400 Hancock Street, Quincy, MA 02169 | (617) 472-1036

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## Women: Are you?

- Pregnant
- Nursing
- Taking birth control pills

## Current Medications

Please list all medications, vitamins, and supplements you are currently taking:

Medication 1: \_\_\_\_\_

Dosage: \_\_\_\_\_

Medication 2: \_\_\_\_\_

Dosage: \_\_\_\_\_

Medication 3: \_\_\_\_\_

Dosage: \_\_\_\_\_

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## Allergies

Please list any allergies you have:

- Penicillin / Antibiotics
- Aspirin / NSAIDs
- Codeine / Narcotics
- Local anesthetics (Novocaine, Lidocaine)
- Latex
- Sulfa drugs
- Iodine
- Other allergies (please list): \_\_\_\_\_

## Dental History

- I have regular dental checkups (every 6-12 months)
- My gums bleed when I brush or floss
- I have sensitive teeth
- I grind or clench my teeth
- I have had orthodontic treatment
- I have had gum surgery / periodontal treatment
- I have dental implants
- I wear dentures or partials

Date of last dental visit: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

## Medical History Review

I certify that the above information is complete and accurate to the best of my knowledge. I understand that it is my responsibility to inform the dentist of any changes in my medical history or health status.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_

Date: \_\_\_\_\_