Fast Check In Med Hx - Active(Copy)(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Patient Medical History

Emergency Contact? ☐

Emergency Contact Phone #? ☐

Do we have your permission to share information regarding your account and or medical/dental treatment?

If yes, please provide name(s) and relationship? ◯ Yes ◯ No If yes ☐

Primary Care Physican Name? ☐

PCP Office Phone number? ☐

Date of Last Exam? ☐

Are you under medical treatment now? ◯ Yes ◯ No If yes ☐

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ◯ Yes ◯ No If yes ☐

Are you taking any medications including non-prescription medicine? ◯ Yes ◯ No If yes ☐

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

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

AIDS/HIV Positive	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Hepatitis A, B or C	◯ Yes ◯ No	Angina	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Autoimmune Disease	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Organ Transplant	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Endocarditis	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No
Fainting Spells/Dizziness	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Back Surgery	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No						

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes ☐

Do you have history of taking an oral or IV Bisphosponate medication (commonly taken for osteoporosis)? ◯ Yes ◯ No

Do you Require Pre-medication Prior to Dental Treatment? ◯ Yes ◯ No

Other? ☐ If yes ☐

Are you allergic to any of the following?

- ☐ Amoxicillin
- ☐ Epinepherin (Epi)
- ☐ Sedatives (Ativan/Valium/Haldon)
- ☐ Azithromycin
- ☐ Local Anesthetics (e.g. Novicain)
- ☐ Metal
- ☐ Clindamycin
- ☐ Latex
- ☐ Penicillin
- ☐ Cephalosporins

Women: Are you...

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

Patient Dental History

Name of Previous Dentist? ☐

Previous Dentist's Location? ☐

Date of Last Dental Exam? ☐

Date of Last Dental Cleaning? ☐

Do you have any sores or lumps in or near your mouth? ◯ Yes ◯ No

Have you had any head, neck, or jaw pain? ◯ Yes ◯ No

Have you ever had any prolonged bleeding following extractions? ◯ Yes ◯ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical staus. I authorize the dentist to realease any information including diagnosis and the records of any treatment or examination rended to me and/ or my child during the period of such dental care to third party and/ or health practitioners.

Signature of Patient, Parent or Guardian:

X Date:____________