MEDICAL HISTORY

Madsen & Hirsch
Dental Care

Name: _____ DOB: ____/____/_____

Physician Name: _____ Primary Clinic Name: _____
Address: _____
When was your last physical exam: _____ Have you been hospitalized in the past 5 years?: _____

CURRENT MEDICATIONS *(Prescriptions and Over the Counter including herbal supplements)*

_____ _____
_____ _____
_____ _____
_____ _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

- ❑ Latex
- ❑ Penicillin
- ❑ Metals
- ❑ Tetracycline
- ❑ Aspirin
- ❑ Anesthetic
- ❑ Codeine
- ❑ Sulfa

Other: _____

HAVE YOU EVER TAKEN:

Yes	No	
❑	❑	Blood Thinners *(ex. Coumadin, Warfarin)*
❑	❑	Steroids *(ex. Prednisone, Cortisone, etc.)*
❑	❑	Cancer medication *(ex. Aredia, Zometa, etc.)*
❑	❑	Anxiety medication
❑	❑	Osteoporosis/Bone Density Medication *(ex. Fosamax, Boniva, Actonel, etc.)*
❑	❑	Pre-Medication for Dental Appointments

ARE YOU NOW OR HAVE YOU EVER REGULARLY:

Past	Current	N/A	
❑	❑	❑	Smoked tobacco?
❑	❑	❑	Used E-Cigarettes?
❑	❑	❑	Chewed tobacco?
❑	❑	❑	Used controlled substances?

Have you had an orthopedic total joint (hip, knee, elbow) replacement?: _____
Date: _____ Any Complications?: _____

WOMEN ARE YOU:

Yes	No	
❑	❑	Pregnant or trying to become pregnant? If yes, How many weeks?: _____
❑	❑	Taking oral contraceptives?
❑	❑	Nursing?

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Yes	No		Yes	No		Yes	No	
❑	❑	Snoring/Sleep Apnea	❑	❑	Cancer	❑	❑	Abnormal Bleeding/ Hemophilia
❑	❑	Sinus Problems	❑	❑	Chemotherapy Treatments	❑	❑	Stomach Ulcers
❑	❑	Neck/Back Pain	❑	❑	Radiation Treatments	❑	❑	Acid Reflux/Heart Burn
❑	❑	Headaches (frequent)	❑	❑	Congenital Heart Defect	❑	❑	Anemia
❑	❑	Asthma	❑	❑	Heart Murmur	❑	❑	Cold/Canker Sores
❑	❑	Diabetes	❑	❑	Heart Attack	❑	❑	Hepatitis
❑	❑	Shortness of Breath	❑	❑	Stroke	❑	❑	HIV Positive/AIDS
❑	❑	Arthritis	❑	❑	Heart Surgery ex. Bypass, Pacemaker	❑	❑	Shingles
❑	❑	Auto-Immune, Skin Eczema, Lupus	❑	❑	Artificial Heart Valve	❑	❑	Tuberculosis Exposure
❑	❑	Hypoglycemia/ Low Blood Sugar	❑	❑	Kidney Stones/ Kidney Disease	❑	❑	Anxiety/Depression
❑	❑	Seizures	❑	❑	High/Low Blood-Pressure	❑	❑	Drug/Alcohol Dependence
❑	❑	COPD	❑	❑	Memory Loss	❑	❑	Eating Disorder
❑	❑	Pre-Diabetes	❑	❑	Hearing Impaired/Loss	❑	❑	Psychiatric Disorders

❑ ❑ Physical Challenges that require accommodation ex. Wheelchair, etc.

Other: _____

Patient Signature: _____ Date: _____

To the best of my knowledge, the information given on this form is accurate. I understand that providing incorrect information can be dangerous to my health. I will not hold my dentist, or any member of his 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. It is my responsibility to inform the dental office of any changes in medical status.