Designing Smiles Medical History

Last Name:	First Name:	Birthdate:	Health Alert:

Name of Medical Doctor: _____ Location/Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications including regular intake of grapefruit, vitamins, herbal supplements, fish oil, etc.

_____

_____

Are you allergic to any of the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Erythromycin	☐	☐	Penicillin	☐	☐	Sulfa
☐	☐	Codeine	☐	☐	Latex	☐	☐	Seasonal	☐	☐	Other: _____

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Alcohol/Chemical Dependency	☐	☐	Diabetes	☐	☐	Neurological Disorders
☐	☐	Anxiety / Nervousness	☐	☐	Epilepsy / Seizures	☐	☐	Osteoporosis/Osteopenia
☐	☐	Asthma/Lung Disease	☐	☐	Glaucoma	☐	☐	Pregnancy/Nursing
☐	☐	Arthritis/Rheumatoid Arthritis	☐	☐	Heartburn / GERD / Reflux	☐	☐	Psychiatric Treatment
☐	☐	Artificial Joints/Valves	☐	☐	Heart Problems	☐	☐	Recreational Drug Use
☐	☐	Blood Transfusion	☐	☐	Mitral Valve Prolapse	☐	☐	Rheumatic Fever
☐	☐	Bulimia/Eating Disorder	☐	☐	Hepatitis	☐	☐	Sinus Trouble
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Sleep Apnea
☐	☐	Cold Sores	☐	☐	HIV / AIDS	☐	☐	Stroke
☐	☐	Chemo/Radiation Therapy	☐	☐	Kidney Disease	☐	☐	Thyroid Disease
☐	☐	Depression	☐	☐	Liver Disease	☐	☐	Tuberculosis

Please list any other Medical Conditions/Recent Surgeries/Hospitalizations that may not be listed above:

_____

Do you consume soda/hard candies/frequent snacks? _____

Tobacco use? ☐ Y ☐ N If Yes, what kind and how much? _____

How would you rate your stress level? ☐ Hig ☐ Moderate ☐ Low

How would you rate the quality of your sleep? ☐ Very Restful ☐ Adequate ☐ Poor/Interrupted

Date: _____ BP: _____ Patient Signature: _____

Med Hx Update: DDS/RDH Signature: _____

Date: _____ BP: _____ Patient Signature: _____

Med Hx Update: DDS/RDH Signature: _____

Date: _____ BP: _____ Patient Signature: _____

Med Hx Update: DDS/RDH Signature: _____

Date: _____ BP: _____ Patient Signature: _____

Med Hx Update: DDS/RDH Signature: _____