HATHCOAT FAMILY DENTAL

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hathcoatfamilydental.com

CONFIDENTIAL MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

		Yes	No
1.	Have you been under the care of a medical doctor during the past two years? If yes, please describe: _____	☐	☐
2.	Physician's Name/Phone/Address: _____		
3.	Have you been a patient in the hospital during the past five years? If yes, please explain: _____	☐	☐
4.	Are you taking any medications, supplements, or vitamins? Please list name/dose: _____ _____	☐	☐
5.	Are you aware of having an allergic (or adverse) reaction to any medication or substance? ☐Penicillin/Antibiotics _____ ☐Sulfa Drugs ☐Anesthetics ☐Nitrous Oxide ☐Aspirin ☐Opioids/Sedatives ☐NSAIDs ☐Codeine ☐Latex ☐Other: _____	☐	☐
6.	Have you lost or gained more than 10 pounds in the past year?	☐	☐
7.	Have you taken antibiotics prior to dental treatment? Name/Reason: _____	☐	☐
8.	Have you ever taken medication to slow/prevent bone loss (osteoporosis)? Medication start date, name, and dose: _____	☐	☐

9. Have you experienced (past or present) any of the following conditions? Mark "Yes" or "No".

	Yes	No		Yes	No		Yes	No
Heart (Surgery,Disease,Attack)	☐	☐	Diabetes	☐	☐	Hepatitis A B C (Circle)	☐	☐
Chest Pain	☐	☐	Thyroid Problems	☐	☐	S.T.D. _____	☐	☐
Congenital Heart Disease	☐	☐	Kidney Trouble	☐	☐	H.I.V.	☐	☐
Heart Murmur	☐	☐	Liver Disease	☐	☐	A.I.D.S.	☐	☐
High Blood Pressure	☐	☐	Jaundice	☐	☐	Cold Sores/Fever Blisters	☐	☐
Mitral Valve Prolapse	☐	☐	Asthma	☐	☐	Blood Transfusion	☐	☐
Artificial Heart Valve	☐	☐	Allergies/Hives	☐	☐	Hemophilia/Excessive Bleeding	☐	☐
Heart Pacemaker	☐	☐	Hay Fever	☐	☐	Sickle Cell Disease	☐	☐
Rheumatic Fever	☐	☐	Sinus Trouble	☐	☐	Bruise Easily	☐	☐
Scarlet Fever	☐	☐	Tuberculosis	☐	☐	Glaucoma	☐	☐
Stroke	☐	☐	Chronic Cough	☐	☐	Contact Lenses	☐	☐
Cortisone Medicine	☐	☐	Emphysema/COPD	☐	☐	Psychiatric Care	☐	☐
Arthritis / Rheumatism	☐	☐	Osteoporosis	☐	☐	Epilepsy or Seizures	☐	☐
Artificial Joint (Hip,Knee, etc.)	☐	☐	Cancer / Tumors	☐	☐	Fainting or Dizzy Spells	☐	☐
Diet (Special/Restricted)	☐	☐	Radiation Therapy	☐	☐	Nervous/Anxiety	☐	☐
Ulcers	☐	☐	Chemotherapy	☐	☐	Depression	☐	☐
Tobacco	☐	☐	Alcohol	☐	☐	Recreational drugs	☐	☐

10. Do you have, or have you had, any disease, condition, or problem not listed? If yes, please describe: _____ ☐ ☐

Women:	Yes	No			Yes	No		Yes	No
11. Are you pregnant?	☐	☐	Weeks?	_____	Nursing?	☐	☐	Birth Control Pills?	☐	☐

I certify that I have read and understand this form and answered all questions to the best of my knowledge. If additional information is needed, Hathcoat Family Dental has permission to contact my health care provider. I will notify Hathcoat Family Dental of any changes in my health/medication(s). The above information is needed to provide safe dental care.

Patient/Guardian Signature: _____ Date: _____

RDH review: _____ DDS Review: _____ Date: _____