Medical History Form

Please bring a printed copy of this form fill out this form electronically or by hand to your appointment.
Thank you! - Your friends at Pine River Dental Arts

Patient Last Name : Last Name... Patient First Name : First Name... Blood Pressure : Blood Pressure...
Physical Address : Physical Address... P : P...

Please check if you have/had :

Heart Attack/Stroke ☐ Yes ☐ No
Other Heart Surgery ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Artificial Heart Valves ☐ Yes ☐ No
Congenital Heart Defect ☐ Yes ☐ No
High/Low Blood Pressure ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No

Kidney Disease ☐ Yes ☐ No
Arthritis/Rheumatism ☐ Yes ☐ No
Tobacco Habit ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Emphysema/COPD ☐ Yes ☐ No
Diabetes: Type I / II A1C ☐ Yes ☐ No
Hypoglycemia ☐ Yes ☐ No

Fainting ☐ Yes ☐ No
Seizures/Epilepsy ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Liver Problems ☐ Yes ☐ No
Autoimmune Disease ☐ Yes ☐ No
Nervousness ☐ Yes ☐ No
Chemotherapy/Radiation ☐ Yes ☐ No
Artificial Joint : Date ☐ Yes ☐ No

Hepatitis A, B or C ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Herpes/Cold Sores ☐ Yes ☐ No
Bleeding Problems ☐ Yes ☐ No
Stomach Ulcers/Acid Reflux ☐ Yes ☐ No
Thyroid Problems ☐ Yes ☐ No
Psychiatric Problems ☐ Yes ☐ No

Please list all current medications, Over-the-counter and Herbal Supplements (or provide list) :
Answer Here...

Please list all Drug/Contact Allergies :
Answer Here...

Do you take blood thinners : ☐ Yes ☐ No If yes, what was your last INR? INR... Date : Date

Have you ever been diagnosed with osteopenia or another medical condition which required bisphosphonate treatment such as Fosamax, Boniva or Actonel? ☐ Yes ☐ No

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? ☐ Yes ☐ No

Has there been any change in your general health within the past year? ☐ Yes ☐ No

If yes, please describe : Answer Here...

Have you had any serious illness, operations or been under the care of a physician in the past 5 years? ☐ Yes ☐ No
If yes, please describe : Answer Here...

Do you have any disease, condition or problem not listed above : Answer Here...

Women Only : Pregnant : ☐ Yes ☐ No Due Date : Date Nursing : ☐ Yes ☐ No

I certify that I have answered the above questions truthfully and to the best of my knowledge. I understand that failure to answer truthfully or withholding medical information may put my health at risk or compromise my dental treatment outcomes. I agree to inform my dentist of any changes to my medical information at upcoming visits.

Patient Signature : _____ Date : _____

Doctor Signature : _____ Date : _____