ERBECK
Family Dental

MEDICAL HISTORY

Last Name First Name MI DOB

Do you have or have had any of the following conditions? Please circle any/all that apply. **__ None of these**

Acid Reflux
Afib
AIDS/ARC/HIV
Alcohol/Drug Abuse
Anemia
Anxious/Nervousness
Arthritis/Rheumatism
Artificial Bones/Joints
__Hip __Knee __Other
Date _____
Surgeon_____
Artificial Heart Valves
Date_____
Surgeon_____
Asthma
Autoimmune Disease
Bleeding Problems
Cancer or Tumors
Chemo/Radiation Therapy
Chest Pains
Cold Sores/Fever Blisters/HPV
Congenital Heart Defect
Diabetes
Emphysema
Epilepsy/Fainting/Seizures
Glaucoma
Heart Attack, Disease, Murmur, **Surgery**
Hepatitis: A B C
High Blood Pressure
Hypoglycemia
Kidney Problems
Liver Problems
Mitral Valve Prolapse
Pacemaker/Defibulator
Psychiatric/Psychological Care
Respiratory Problems
Rheumatic Fever
Shingles
Sinus Problems
Stroke
TMJ Problems
Tuberculosis (TB)
Venereal Disease

Please list any other medical conditions not listed: _____

Do you take any drugs or medications (prescription and/or over-the-counter)?
Please list all drugs/medications including dosages below or on a separate page.

Are you allergic to any of the following? ☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Metal ☐ Acrylic ☐ Latex

☐ Local Anesthetics ☐ Sulfa Drugs ☐ Iodine ☐ Other If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? YES/NO

Is Pre-Medication required? YES/NO

Do you have a Tobacco Habit? YES/NO

WOMEN ONLY:
Are you currently pregnant? YES/NO
Currently nursing? YES/NO

Name of Physician_____ Phone: _____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature of Patient, Parent, or Guardian: _____ Date: _____