{Patient Label]

FAMILY HealthCare

MEDICAL INFORMATION

Patient Name:	Birth Date:	Date of Last Dental Visit:
Emergency Contact:	Relationship:	Phone:
Primary Physician:	Last Visit Date:	Phone:
Specialist Physician(s): [Cardiologist, OBGYN, etc.]	Last Visit Date:	Phone:

1.) Do you have or have you ever had any of the following:

CARDIOVASCULAR	☒	NERVOUS SYSTEM	☒	RESPIRATORY	☒	ENDOCRINE	☒
CAD (heart attack/failure)	☐	Epilepsy/Seizures	☐	Emphysema/COPD	☐	Thyroid Disorder	☐
Angina/Chest Pains	☐	Anxiety or Panic Attacks	☐	Seasonal Allergies	☐	Adrenal Disorder	☐
High Blood Pressure	☐	ADHD	☐	Chronic Bronchitis	☐	Diabetes- Type:	☐
Low Blood Pressure	☐	Autism	☐	Asthma	☐	Immune Disorder	☐
Arrhythmias (irregular heartbeat)	☐	Psychosis or Mania	☐	Sinus Problems	☐	Currently Pregnant	☐
Congenital Heart Defect	☐	Headaches/Migraines	☐	Obstructive Sleep	☐	Due Date: / /	
Valve Disease	☐	Substance Abuse	☐	**MISCCELLANEOUS**	☒	Breastfeeding	☐
Artificial Heart Valve	☐	Alzheimer's/Dementia	☐	Cancer- Type:	☐	**EXCRETORY**	☒
Endocarditis (Heart Infection)	☐	Physical/Mental Impairment	☐	Joint Replacements	☐	Liver Disorder	☐
Stroke or TIA	☐	**INFECTIONS**	☒	Organ Transplant	☐	Kidney Disorder	☐
Bleeding Problems	☐	Hepatitis- Type:	☐	Osteoporosis	☐	Bladder Disorder	☐
Blood Cell Disorder	☐	HIV/AIDS	☐	Tobacco Use	☐	Reflux/GERD/Ulcers	☐
Heart Murmur	☐	Tuberculosis	☐	Hearing Loss	☐	Intestinal Problems	☐

2.) Please be more specific and list any medical problems and/or surgeries that you have that are not listed on the table above:

3.) Do you take any **BLOOD THINNERS** such as warfarin (Coumadin), clopidogrel (Plavix) or dabigatran etexilate (Pradaxa)? Y / N

4.) Do you take or have you ever taken any **BISPHOSPHONATES** such as risedronate (Actonel), alendronate (Fosamax), ibandronate (Boniva), zoledronic acid (Reclast), or pamidronate (Aredia)? Y / N ***If yes, please circle drug name.**

5.) Please list ALL medications you are taking below, including non-prescription products. Do any cause dry mouth? Y / N

6.) Please list any allergies you have to medications, food, or any other substances:

7.) Have you ever received a local anesthetic? Y / N A general anesthetic? Y / N If so, any problems? Y / N

8.) Home water source: ☐City ☐Well Do you use fluoride toothpaste? Y / N Any other forms of fluoride? Y / N

I certify that I have read and understand the above and that the information given on this form is accurate and request and authorize this clinic to accept me as a patient and treat me for conditions identified during evaluation.

_____ _____

Patient or Parent/Guardian Date

_____ _____

Interpreter Date