TIENT MEDICAL HISTORY

Ages 14 +

Patient Name:_____ **Date of Birth:**_____

Medical Doctor's Name:_____ Date of Last Medical Dr. Visit:_____

Physician's Phone number: _____

(Women): Are you pregnant? **YES/NO** Nursing? **YES/NO** Taking birth control? **YES/NO**

Check if you currently have or have had any of the following:

___Anemia
___Arthritis
___Artificial Heart Valve
___Asthma
___Back Problems
___Bleeding Abnormally
___Blood Disease
___Cancer
___Chemical Dependency
___Chemotherapy
___Cough - Persistent
___Diabetes
___Dementia
___Epilepsy
___Fainting
___Glaucoma
___Headaches/Migraines
___Heart Condition
___Hemophilia
___Hepatitis
___Herpes/Cold Sores
___High Blood Pressure
___HIV/AIDS
___Jaw Pain
___Kidney Disease
___Liver Disease
___Pacemaker
___Radiation Treatment
___Respiratory Disease
___Shortness of Breath
___Stroke
___Swelling of Feet/Ankles
___Thyroid Problems
___Tuberculosis
___Ulcer
___Vision/Hearing Trouble

**Details or other conditions/health issues: _____

Tobacco/cannabis/vaping Use? **YES/NO If yes, type/frequency: _____

Have you had any serious illness/operation? **YES/NO If yes, describe: _____

Are you currently taking a blood thinner? **YES/NO If so, which one? _____

Have you been diagnosed with Osteoporosis? **YES/NO If so, are you currently receiving treatment? **YES/NO**

****Do you have any artificial joints? **YES/NO** If so, what type(s) and dates of surgery? _____

****Do you require antibiotic premed prior to dental treatment? **YES/NO** If so, which one? _____

List medications you are currently taking and the correlating diagnosis:

_____
_____
_____
_____
_____

Allergies:

_____
_____
_____
_____
_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my Doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature Date

_____ _____

Dentist Signature Date