Time 10:28 AM | J. Scott Thompson, D.M.D., P.C. | Date 3/1/2023

2023 Medical HX-FINAL(Copy)

Patient Name: | Birth Date: | Date Created:

Medical Alert:

Emergency Contact:

Do you require a dental premedication?	◯ Yes ◯ No	If yes
Are you under a physician's care now? Physician's name?	◯ Yes ◯ No	If yes
Any recent hospitalizations or ever had a major surgery?	◯ Yes ◯ No	If yes
Are you taking any medications, supplements, or recreational drugs?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco? Smoke, Chew or Vape?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Taking oral contraceptives?

Allergic to any Medications? Other Allergies? ☐ If yes

Do you have, or have you had, any of the following?

Acid Reflux ◯ Yes ◯ No	Contact Lenses ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Nervous/Anxiety ◯ Yes ◯ No
AIDS/HIV Positive ◯ Yes ◯ No	Depression ◯ Yes ◯ No	Hempophilia/Clotting Disorder ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No
Alzheimer's/Dementia ◯ Yes ◯ No	Diabetes Type I ◯ Yes ◯ No	Hepatitis A, B, or C ◯ Yes ◯ No	Pain in Jaw ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Diabetes Type II ◯ Yes ◯ No	Herpes/Cold Sores ◯ Yes ◯ No	Parkinson's ◯ Yes ◯ No
Angina or A-FIB ◯ Yes ◯ No	Drug/Alcohol Addiction ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Radiation ◯ Yes ◯ No
Aphthous Ulcers/Canker Sores ◯ Yes ◯ No	Dry Mouth ◯ Yes ◯ No	High Cholsterol ◯ Yes ◯ No	Rhematism ◯ Yes ◯ No
Arthritis ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	Hives/Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artifical Heart Valve ◯ Yes ◯ No	Epilepsy or Siezures ◯ Yes ◯ No	HPV ◯ Yes ◯ No	Shortness of Breath ◯ Yes ◯ No
Artifical Joint Replacement ◯ Yes ◯ No	Fainting/Dizziness ◯ Yes ◯ No	Hyperglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Stomach or Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Headaches/Migraines ◯ Yes ◯ No	Kidney Disease/Jaundice ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Gums Bleed/Recession ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Muliple Sclerosis ◯ Yes ◯ No	Tumors ◯ Yes ◯ No
Clenching or Grinding of Teeth ◯ Yes ◯ No	Heart Disease ◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____