North Seattle Smiles

**PATIENT MEDICAL HISTORY**

**Patient Name:** _____ **Patient Birthdate:** _____

***Has a physician or other provider required or strongly recommended taking a pre-medication prior to dental treatment? If so, please list the medication / reason:*** _____

**Physician Information:**
Do you have a Primary Care Physician? Yes No
Physician's name and clinic: _____ Phone: _____

**Have you ever been hospitalized or had a major operation? If so, please explain:**
_____

**Medications:** Please list all medications and reason for taking:
_____
_____
_____

**Do you smoke or use tobacco products?** Yes No If yes, please explain: _____

**Are you taking or have taken a biphosphate (i.e, Fosamax, Actonel, Didronel, Boniva, Bonefros)?** Yes No

**Drug Allergies:** Are you allergic to any of the following? **Please circle any that apply**
*Aspirin Penicillin Other Antibiotics Codeine Acrylic Metal Latex Local Anesthetics Other*

**If yes, please explain:** _____

Are you pregnant (or think you may be pregnant)? Yes No

**Medical Conditions:** ***Circle any condition that have or have had in the past. Please circle any that may apply:***

| | | | |
|---|---|---|---|
| *Heart Condition* | *Diabetes* | *Gastro-esophogeal Reflux* | *Chemical Dependency* |
| *Heart Surgery* | *High Blood Pressure* | *Hemophilia* | *Psychiatric Treatment* |
| *Heart Disease* | *Hepatitis* | *Bleeding Disorder* | *Depression/Anxiety* |
| *Heart Attack* | *Kidney Disease* | *Thyroid Disease* | *Seizures/Epilepsy* |
| *Stroke* | *HIV/AIDS* | *Rheumatic Fever* | *Neurological Problems* |
| *Angina* | *Arthritis/Gout* | *Scarlet Fever* | *Fluctuating Weight* |
| *Pacemaker* | *Asthma* | *Cold Sores* | *Sleep Apnea* |
| *Lung Disease* | *Emphysema* | *Artificial Heart Valve* | *Cancer* |
| *Osteoporosis* | *Tuberculosis* | *Artificial Joint/Limb/Device* | *Radiation Therapy/Chemotherapy* |

**Have you had or do you have a serious illness or medical condition not listed above?**
If so, please explain: _____

**Patient Signature:** _____ **Today's Date:** _____

If patient is a minor, Parent/Guardian Name (print): _____
**Parent/Guardian Signature:** _____ **Today's Date**:_____