DENVER
FAMILY DENTISTRY

Patients Name : ______________________________

Patients Medical History

Name of Family physician: ______________________________ **Phone Number**: ____________________

How is your overall general Health? ☐Excellent ☐Good ☐Fair ☐Poor

Date of last Medical Exam: ____________________ **Nature of Exam**: ______________________________

Please check all that apply:

☐ Abnormal Bp High___Low___	☐ Chemo-Therapy	☐ Hearing Aid/Loss	☐ Rheumatic Fever
☐ Aids	☐ Congenital Heart Problem	☐ Hepatitis TYPE ___	☐ Sinus Trouble/ Sinusitis
☐ Angina/Chest Pain	☐ Diabetes TYPE ____	☐ Herpes Virus/Cold Sores	☐ Stroke
☐ Artificial Hip/Joint/Limb	☐ Epilepsy/Seizures	☐ HIV Positive	☐ Thyroid Disease
☐ Asthma	☐ Frequent Headaches	☐ Kidney Trouble	☐ Ulcers/Colitis
☐ Bacterial Endocarditis	☐ Heart Valve Replacement	☐ Liver Trouble	☐ Other ____________
☐ Breathing Problems	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ **NONE OF THE ABOVE**
☐ Bleeding Disorder	☐ Heart Trouble	☐ Pacemaker	
☐ Cancer/Tumors	☐ Heart Surgery	☐ Radiation Therapy	

Have you ever had a serious illness or operation? ☐YES ☐NO **Please Explain**: ______________________________

Have you been hospitalized during the past five years? ☐YES ☐NO **Why?** ______________________________

Are you limited in activity because of a physical or medical condition? ☐YES ☐NO

Are you currently taking any medications, pills, drugs or supplements? ☐YES ☐NO
Please list: ____
____

Have you ever taken medication for osteoporosis such as Fosamax, Boniva, Actonel. If so please list ☐YES ☐NO
____

Have you ever had any serious problems associated with previous dental treatment or dental anesthetic? ☐YES ☐NO
Please explain: ____

Do you smoke/chew tobacco products? ☐YES ☐NO **How Often?** ____________ **Length of use?** ____________________

Women: Do you take birth control? ☐YES ☐NO
Are you Pregnant (if maybe check yes)? ☐YES ☐NO **If yes please give delivery date:** ____________________
Are you Nursing? ☐YES ☐NO
Is there any other disease, condition, or problem not listed above? ☐YES ☐NO
Please explain: ____

Are you allergic to (please check)

☐ Aspirin	☐ Latex	☐ Pain Medications
☐ Codeine	☐ Local Anesthetic	☐ Penicillin
☐ Erythromycin	☐ Metals	☐ Sulfa

Please list any other allergies: ____

I, the undersigned (patient or legal guardian), certify that the information given on this form is true and correct.

Patient/Legal Guardian Signature: ______________________________ **Date:** ____________________