CEDAR STREET
FAMILY DENTISTRY

Medical Information

Patient name: _____ Today's date: _____

Current medications: _____ _____ _____

_____ _____ _____

Allergies: _____ _____ _____

Do you have any of the following? circle yes or no

Anemia	yes no	Head Injuries	yes no	Pregnancy	yes no
Anorexia/Bulimia	yes no	Heart Disease	yes no	Pre-Medicate	yes no
Arthritis	yes no	Heart Murmur	yes no	Radiation treatment	yes no
Asthma	yes no	Heart surgery	yes no	Respiratory issues	yes no
Bisphosphonates	yes no	Hepatitis	yes no	Rheumatic Fever	yes no
Birth Control	yes no	High Blood Pressure	yes no	Seizures	yes no
Blood Clot	yes no	HIV	yes no	Sinus/Allergies	yes no
Blood Disease	yes no	Jaundice	yes no	Sleep Apnea	ye no
Blood Thinner	yes no	Joint Replacement	yes no	Stroke	yes no
Cancer	yes no	Kidney Disease	yes no	Substance Abuse	yes no
Diabetes type I or II	yes no	Liver Disease	yes no	STD	yes no
Dizziness	yes no	Mental Disorders	yes no	Thyroid Disease	yes no
Dry Mouth	yes no	Mitral Valve Prolapse	yes no	TMJ Disorder	yes no
Epilepsy	yes no	Mouth Ulcers	yes no	Tobacco Usage	yes no
Excessive Bleeding	yes no	Nervous Disorder	yes no	Tuberculosis	yes no
Fainting	yes no	Pacemaker	yes no	Tumors	yes no
Glaucoma	yes no	Other _____			

Medical History Continued:

Have you ever had any complication following dental treatment? YES NO

If yes, please explain:

_____

Have you ever been admitted to the hospital or needed emergency care during the past two years? YES NO

If yes, please explain:

_____

Are you now under the care of a physician? YES NO

If yes, please explain:

_____

Do you have any health conditions that need further clarification? YES NO

If yes, please explain:

_____

Have you ever taken antibiotics prior to having your teeth cleaned or before dental work? YES NO

If yes, please explain:

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. Should I have a change in my health, I will inform the doctors at the next appointment.

Signature: _____ Date: _____ Relationship to patient: _____
(signature of patient, parent or guardian)