{Patient Label]

FAMILY HealthCare

# MEDICAL INFORMATION

| Patient Name: | Birth Date: | Date of Last Dental Visit: |
|---|---|---|
| Emergency Contact: | Relationship: | Phone: |
| Primary Physician: | Last Visit Date: | Phone: |
| Specialist Physician(s): [Cardiologist, OBGYN, etc.] | Last Visit Date: | Phone: |

1.) Do you have or have you ever had any of the following:

| CARDIOVASCULAR | ☒ | NERVOUS SYSTEM | ☒ | RESPIRATORY | ☒ | ENDOCRINE | ☒ |
|---|---|---|---|---|---|---|---|
| CAD (heart attack/failure) | ☐ | Epilepsy/Seizures | ☐ | Emphysema/COPD | ☐ | Thyroid Disorder | ☐ |
| Angina/Chest Pains | ☐ | Anxiety or Panic Attacks | ☐ | Seasonal Allergies | ☐ | Adrenal Disorder | ☐ |
| High Blood Pressure | ☐ | ADHD | ☐ | Chronic Bronchitis | ☐ | Diabetes- Type: | ☐ |
| Low Blood Pressure | ☐ | Autism | ☐ | Asthma | ☐ | Immune Disorder | ☐ |
| Arrhythmias (irregular heartbeat) | ☐ | Psychosis or Mania | ☐ | Sinus Problems | ☐ | Currently Pregnant | ☐ |
| Congenital Heart Defect | ☐ | Headaches/Migraines | ☐ | Obstructive Sleep | ☐ | Due Date: / / | |
| Valve Disease | ☐ | Substance Abuse | ☐ | **MISCCELLANEOUS** | ☒ | Breastfeeding | ☐ |
| Artificial Heart Valve | ☐ | Alzheimer's/Dementia | ☐ | Cancer- Type: | ☐ | **EXCRETORY** | ☒ |
| Endocarditis (Heart Infection) | ☐ | Physical/Mental Impairment | ☐ | Joint Replacements | ☐ | Liver Disorder | ☐ |
| Stroke or TIA | ☐ | **INFECTIONS** | ☒ | Organ Transplant | ☐ | Kidney Disorder | ☐ |
| Bleeding Problems | ☐ | Hepatitis- Type: | ☐ | Osteoporosis | ☐ | Bladder Disorder | ☐ |
| Blood Cell Disorder | ☐ | HIV/AIDS | ☐ | Tobacco Use | ☐ | Reflux/GERD/Ulcers | ☐ |
| Heart Murmur | ☐ | Tuberculosis | ☐ | Hearing Loss | ☐ | Intestinal Problems | ☐ |

2.) Please be more specific and list any medical problems and/or surgeries that you have that are not listed on the table above:

3.) Do you take any **BLOOD THINNERS** such as warfarin (Coumadin), clopidogrel (Plavix) or dabigatran etexilate (Pradaxa)? Y / N

4.) Do you take or have you ever taken any **BISPHOSPHONATES** such as risedronate (Actonel), alendronate (Fosamax), ibandronate (Boniva), zoledronic acid (Reclast), or pamidronate (Aredia)? Y / N ***If yes, please circle drug name.**

5.) Please list ALL medications you are taking below, including non-prescription products. Do any cause dry mouth? Y / N

6.) Please list any allergies you have to medications, food, or any other substances:

7.) Have you ever received a local anesthetic? Y / N A general anesthetic? Y / N If so, any problems? Y / N

8.) Home water source: ☐City ☐Well Do you use fluoride toothpaste? Y / N Any other forms of fluoride? Y / N

**I certify that I have read and understand the above and that the information given on this form is accurate and request and authorize this clinic to accept me as a patient and treat me for conditions identified during evaluation.**

_____ _____

Patient or Parent/Guardian Date

_____ _____

Interpreter Date