GIFFORD FAMILY DENTISTRY
Gentle • Friendly • Trusted

Medical History

Physician's Name:_____

Address/Clinic:_____

Phone #: _____Date of last visit:_____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain:_____

_____

Do you use alcohol? Yes No

Do you smoke or use tobacco in any other form? Yes No

Have you ever taken Fosamax or any other medication for bone preservation? Yes No

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Unsure Yes No

Week #_____ Are you nursing? Yes No

Please check all conditions that you do have or have experienced in the past

☐Heart Problems / Surgery ☐Congenital Heart Defects ☐Diabetes (I / II) ☐Epilepsy/Seizures ☐Sexually Transmitted Disease

☐Low Blood Pressure ☐Pacemaker ☐Liver Problems ☐Headaches ☐High Blood Pressure

☐Asthma, Emphysema ☐Hepatitis (A, B, or C) ☐Anxiety ☐Lupus ☐Abnormal Bleeding / Disorder

☐Persistent Cough ☐Kidney Problems ☐Psychiatric Problems ☐Arthritis ☐Anemia

☐Tuberculosis ☐Stroke ☐Artificial Bones/Joints ☐Drug Abuse ☐Endocarditis

☐Ulcers ☐Depression ☐Cancer ☐Glaucoma ☐Artificial Heart Valve

☐Colitis or Irritable Bowel ☐Dizzy or Fainting Spells ☐HIV/AIDS ☐Thyroid Problems

☐Blood Transfusion ☐Hay Fever ☐Herpes/Fever Blister ☐Radiation/Chemotherapy

☐Rheumatic/Scarlet Fever ☐Shingles ☐Sinus Problems ☐Hospitalized for any reason

_____

_____

_____

Please list any serious medical condition(s) that you have experienced: _____

_____

Please list all prescription/over the counter drugs, blood thinners or heart medications you are taking or have taken in the last 30 days:

_____

_____

Are you allergic to any of the following? Please circle all that apply

Aspirin	Codeine	Erythromycin	Latex	Sedatives	Tetracycline
Dental Anesthetics	Jewelry / Metals	Penicillin	Sulfa Drugs	Other	Barbiturates

Please list anything additional that causes allergic reactions: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

Patient Name:_____

_____ _____

Parent or Guardian Signature Date Patient Signature Date

Medical History Update

I have read my medical history dated _____ and confirmed that it states past and present medical condition_____

Initial Date

I have read my medical history dated _____ and confirmed that it states past and present medical condition_____

Initial Date

I have read my medical history dated _____ and confirmed that it states past and present medical condition_____

Initial Date