~ Amherst Dental Group, PC Patient Medical History Form ~

Patient Name: Birth Date: Date Created:

Are you under a physician's care for a current health issue? If so, please describe.	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation? If so, please describe.	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury? If so, please describe.	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel, Reclast? If so, please describe.	○ Yes ○ No	If yes
Have you used controlled substances? What kind? How often?	○ Yes ○ No	If yes
Are you on a special diet? If so, please describe.	○ Yes ○ No	If yes
Do you use tobacco? How often?	○ Yes ○ No	If yes

Please list all medications:

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Clindamycin	☐ Amoxicillin		

Please list anything else that you are allergic to:

Women~ Are you:

Pregnant / Trying to get pregnant?	○ Yes ○ No
Taking oral contraceptives?	○ Yes ○ No
Nursing?	○ Yes ○ No

Do you have, or have you ever had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No	Anaphylaxis	○ Yes ○ No	Anemia	○ Yes ○ No
Angina	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Artificial Joint	○ Yes ○ No
Asthma	○ Yes ○ No	Blood Disease	○ Yes ○ No	Blood Transfusion	○ Yes ○ No	Breathing Problems	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Cancer	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Chest Pains	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No	Convulsions	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No
Diabetes	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Emphysema	○ Yes ○ No	Epilepsy/Seizures	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Frequent Headaches	○ Yes ○ No
Glaucoma	○ Yes ○ No	Hay Fever	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Heart Murmur	○ Yes ○ No
Heart Pacemaker	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Hemophilia	○ Yes ○ No	Hepatitis A	○ Yes ○ No
Hepatitis B or C	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Hives/Rash	○ Yes ○ No
Hypoglycemia	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Leukemia	○ Yes ○ No
Liver Disease	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Lung Disease	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No
Oral Herpes	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No
Psychiatric Care	○ Yes ○ No	Radiation Treatment	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Rheumatism	○ Yes ○ No	Scarlet Fever	○ Yes ○ No	Shingles	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Sinus Trouble	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No	Stroke	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Thyroid Disease	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Tumors/Growths	○ Yes ○ No	Ulcers	○ Yes ○ No
Yellow Jaundice	○ Yes ○ No						

Is there any other important medical information that we should be aware of?

Primary Care Physician's Name:

Signature of Patient, Parent or Guardian:

X

Date:_____