



MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____ Weight _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

Form with two columns of medical history questions (1-57) and checkboxes for YES/NO.

Have you ever been advised to pre-medicate for dental treatment? If so, what for?

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and or vitamins taken within the last two years

Table for listing medications with columns for Drug and Purpose.

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____