DRS. LEVY & VUTERA
FAMILY DENTISTRY

# Patient Medical History Form

Name: _____ DOB:_____ Date:_____

1. Are you now under a physician's care ? Yes____ No____
   _____
2. Are you regularly taking aspirin or any anticoagulant (blood thinners)? Yes____ No____
3. Are you taking any medication for osteoporosis? Yes____ No____
4. Have you ever had severe bleeding or other complications following an extraction? Yes___ No___
5. Are you pregnant? Yes____ No____
6. Are you taking any birth control pills? Yes____ No____
7. Have you been admitted to a hospital or needed emergency care within the past 2 years? Yes____ No____
   _____
   _____
8. Have you been diagnosed with sleep apnea or have issues snoring? Yes____ No____
   Please Explain:
   _____
9. Do you smoke, vape, or use tobacco products? Yes____ No____ If yes, what type and how often:
   _____
10. Please list surgeries:
    _____
    _____
11. List all prescriptions medications, over the counter medications, or supplements:
    _____
    _____
    _____

**Are you allergic to:**

____Aspirin ____Penicillin ____Codeine ____Acrylic
____Metal ____Latex ____Sulfa Drugs ____Local Anesthetic
____Clindamyacin

Other? Please List:
_____
_____

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Please check if you have or had any of the following.

**Premedication**:

***** If this appears next to a condition listed above, you may need premedication for certain dental procedures.

| | | | | | |
|---|---|---|---|---|---|
| ADD/ADHD | | Alzheimer's Disease | | Glaucoma | |
| Anemia | | Angina/Chest Pains | | Heart Disease /Afib | |
| Anxiety | | Artificial Heart Valve * | | Hemophilia | |
| Blood Transfusion | | Bruise Easily | | Hypoglycemia | |
| Chemotherapy | | Cold Sores/Fever Blisters | | Mitral Valve Prolapse * | |
| Down Syndrome | | Emphysema | | Radiation Treatments | |
| Excessive Thirst | | Fainting Dizziness | | Spina Bifida | |
| Hepatitis B or C | | Heart Attack | | Tuberculosis | |
| Heart Pacemaker * | | Heart Disorder (Congenital) | | Vision impaired | |
| High Blood Pressure | | High Cholesterol | | Herpes | |
| Liver Problems | | Low Blood Pressure | | Heart Murmur | |
| Osteoporosis | | Mental Disorders | | HIV+ or AIDS | |
| Shortness of Breath | | Sickle Cell Disease | | Kidney Problems | |
| Surgical Shunt * | | Thyroid Problems | | Osteopenia | |
| Sensory Disorder | | Hearing impaired | | Shingles | |
| Asthma | | Allergies/Sinus Problems | | Stroke | |
| Arthritis | | Autism Spectrum Disorders | | Ulcers | |
| Artificial Joint or Disc * | | Blood Disease | | Diabetes | |
| Breathing Problems | | Cancer | | Epilepsy or Seizures | |
| Excessive Bleeding | | Dementia | | | |

Have you ever been diagnosed with a condition not listed? Yes____ No____ If yes, Please List:

_____

_____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X_____ Date: _____