Emerald
DENTAL STUDIO

**Medical History Form**

Last Name:_____ First Name:_____ Birth Date:_____

1. If you have any heart conditions, please explain:_____

2. If you have been hospitalized, been to the ER, or have had a serious illness in the past 3 years, please explain:_____

3. List any conditions for which you are currently being treated for by a physician:_____
_____

4. If you are currently in any pain, please explain:_____

5. If you smoke, please list what and how often:_____

6. If you have diabetes, what type and is it controlled?_____

7. Are you pregnant or breastfeeding?_____ If pregnant, what month?_____

Have you experienced any of the following within the PAST MONTH?

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| _ | _ | Shortness of breath | _ | _ | Sinus problems |
| _ | _ | Fainting | _ | _ | Fever |
| _ | _ | Chest pain | _ | _ | Blurred vision |
| _ | _ | Bleeding problems | _ | _ | Difficulty swallowing |

Have you had or do you have any of the following?/

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| _ | _ | Heart Attack | _ | _ | High Blood Pressure |
| _ | _ | Heart Disease | _ | _ | Tumors/Cancer |
| _ | _ | Artificial Joint | _ | _ | Chemo/Radiation |
| _ | _ | Stomach Ulcer | _ | _ | Emphysema/Lung Disease |
| _ | _ | Arthritis/Rheumatism | _ | _ | Kidney/Bladder Disease |
| _ | _ | Skin Disease | _ | _ | Liver Disease |
| _ | _ | Seizures | _ | _ | Anxiety/Depression |
| _ | _ | Stroke | _ | _ | Osteoporosis |
| _ | _ | Asthma | _ | _ | Herpes/Cold Sores |
| _ | _ | Thyroid Disease | _ | _ | AIDS/HIV |

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Are you allergic to any of the following?

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| _ | _ | Anesthetic | _ | _ | Iodine |
| _ | _ | Aspirin | _ | _ | Latex |
| _ | _ | Codeine | _ | _ | Penicillin |
| _ | _ | Ibuprofen | _ | _ | Metals |
| _ | _ | Sulfa | | | |

Other allergies:_____

| Y | N | |
|---|---|---|
| _ | _ | Unusual reaction to dental injections. If yes, explain:_____ |

_____

| Y | N | |
|---|---|---|
| _ | _ | Do you have any medical conditions not listed on this form? |

If yes, explain:_____

Explain if you have ever had to take antibiotics before a dental appointment:_____

_____

List all medications that you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

All patients: I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his or her staff, responsible for any errors or omissions that I have made in the completion of this form.

Date:_____

Signature:_____