Time 11:35 AM | John M. Schiefelbein, DMD, PLLC | Date 4/28/2017

MEDICAL HISTORY

Patient Name: | Birth Date: | Date Created:

Do you have a current physician? If so, please write their name(s):	Yes No	If yes	
Do you know the date of your last dental exam?	Yes No	If yes	
Have you been hospitalized or had a major operation within the past 5 years?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you smoke or use tobacco?	Yes No	If yes	
Have you ever been told to premedicate with antibiotics prior to dental treatment?	Yes No	If yes	
Have you ever been prescribed Aspirin, Coumadin, Plavix or any other blood-thinning medicine?	Yes No	If yes	
Do you have a primary dental concern at this time?	Yes No	If yes	
Does dental treatment make you nervous?	Yes No	If yes	
Have you ever had any serious trouble associated with previous dentistry?	Yes No	If yes	
Are you happy with the appearance of your teeth?	Yes No		

For women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

Have you ever taken an osteoporosis medication such as Fosamax, Boniva or other?	Yes No	If yes	

Are you allergic to any of the following?

☐ Penicillin ☐ Codeine ☐ Metal ☐ Latex
☐ Local Anesthetics ☐ Sulpha

Other allergies:	Yes No	If yes	

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

Artificial Joint Yes No	Cardiac Transplant Yes No	Sinus Trouble Yes No	Alzheimer's Disease Yes No
Cancer-Malignancy Yes No	Congenital Heart Disease Yes No	Stroke Yes No	Psychiatric Care Yes No
Joint Infection Yes No	Artificial Heart Valve Yes No	Heart Attack Yes No	Drug Addiction Yes No
Hemophilia Yes No	Infective Endocarditis Yes No	Angina Yes No	Hypoglycemia Yes No
Diabetes Yes No	Abnormal Blood Pressure Yes No	Frequent Headaches Yes No	Fainting/Dizziness Yes No
Rheumatoid Arthritis Yes No	TMJ Problems Yes No	Congestive Heart Failure Yes No	Epilepsy or Seizures Yes No
Drug or Radiation-Induced Immunosuppress Yes No	Dry Mouth Yes No	Emphysema/COPD Yes No	Excessive Bleeding or Bruising Yes No
Systemic Lupus Yes No	Periodontal/Gum Disease Yes No	Asthma Yes No	Thyroid Disease Yes No
AIDS/HIV Positive Yes No	Cold Sores Yes No	Hepatitis Yes No	Pacemaker Yes No

Have you ever had any serious illness not listed above?	Yes No	If yes	

Comments:

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:_____