Michael D. Vanover, D.D.S., P.A.
Family & Cosmetic Dentistry For All Ages

Patient Medical History

Patient's Name: _____ Date: _____

1. Have you been under the care of a medical doctor in the past 2 years? Yes No
   If so, for what condition? _____

Doctor's Name	Condition/Treatment	Date

2. List all medications taken in the last 6 months: _____
   _____
   _____
3. Are you sensitive or allergic to any medications? (Penicillin, Aspirin, Codeine, Erythromycin, Iodine, Latex, Tetracycline, Cephalosporins, Clindamycin, Epinephrine, Sulfa Meds, ….) Yes No
   Others: _____
   _____
4. Are you sensitive or allergic to any metals? Yes No
5. Women: Are you pregnant or anticipate becoming pregnant? Due Date:_____ Yes No
   Are you taking oral birth control pills? Yes No
6. Has a physician ever told you that you have a medical condition which requires you to take an Antibiotic Pre-Medication prior to any dental treatment? Yes No

Please circle any of the following conditions with which you have been diagnosed (past or present) by a physician.

Cardiovascular/Heart

1. Heart murmur
2. Rheumatic fever
3. Mitral valve prolapse
4. Artificial heart valve
5. High or Low blood pressure
6. Heart failure
7. Heart disease or heart attack
8. Angina pectoris
9. Heart pacemaker
10. Heart surgery
11. Other heart problem: _____
12. Stroke
13. COPD
14. None known

Other

1. Diabetes
2. Artificial joint
3. Liver disease or Kidney trouble
4. Hepatitis Type: A, B, C
5. Excessive bleeding or Hemophilia
6. Organ transplant or Organ removal
7. Blood transfusion
8. Cancer or Tumor
9. Chemotherapy or Radiation therapy
10. Epilepsy or Seizures
11. Asthma
12. Sinus trouble
13. Emphysema
14. Tuberculosis
15. Arthritis: Oesteo, Rheumatoid
16. Lupus
17. GI disorder: (Gastric bypass, GERD, Ulcer, Diverticulitis, Crohn's dis.)
18. Thyroid trouble
19. Glaucoma
20. TMJ/TMD
21. Psych (depression, anxiety, etc)
22. AIDS, HIV
23. Herpes, (Cold sores/Fever blisters)
24. Deaf or Hard-of-hearing
25. Tobacco Use: Smoke / Chew Tobacco
26. Paget's disease
27. Ever taken: Zometa, Aredia, Actonel, Fosamax, Bonefos, Boniva, Didronel, Ostac, Skelid, or Other Bisphosphonate medications.

To the best of my knowledge, all of the information provided is correct. If I have any changes in my health or medications I will notify my dentist at the next appointment.

_____ _____ _____ _____
Signature of Patient, Parent or Guardian Date Signature of Dentist Date

Medical History Updates:
_____ Date: _____ Initials: ____
_____ Date: _____ Initials: ____
_____ Date: _____ Initials: ____