STEFAN
FAMILY DENTAL

Medical History

Patient Name _____ Date _____

Physician's Name _____ Date of last physical _____

Are you taking any medications, OTC drugs, or supplements? _____ Please List _____

_____

History of hospitalizations or major operations _____

Have you ever taken any medications containing bisphosphonates? _____

Do you use any tobacco products or vape? _____ If yes, how often? _____

Do you use controlled substances? _____

Are you on a special diet? _____ Type of diet _____

Any allergies to:

___ Aspirin
___ Penicillin/Amoxicillin
___ Codeine
___ Sulfa Drugs
___ Latex
___ Local Anesthetics
___ Other

For Women:

Pregnant/trying to become pregnant? _____ Nursing? _____ Taking oral contraceptives? _____

Do you have, or have you had any of the following? Please check next to any that apply.

___ AIDS/HIV Positive
___ Alzheimer's Disease
___ Anaphylaxis
___ Anemia
___ Arthritis
___ Artificial Heart Valve
___ Artificial Joint
___ Asthma
___ Bleeding Disorder
___ Breathing Problems
___ Cancer
___ Congenital Heart Disorder
___ Convulsions
___ Defibrillator
___ Diabetes
___ Drug Addiction
___ Emphysema/COPD
___ Fainting/Dizziness
___ Frequent Headaches
___ Heart Attack
___ Heart Disease
___ Hemophilia
___ Hepatitis
___ Herpes
___ High Blood Pressure
___ High Cholesterol
___ Irregular Heartbeat/A-fib
___ Kidney Problems
___ Leukemia
___ Liver Disease
___ Low Blood Pressure
___ Lung Disease
___ Osteoporosis
___ Pacemaker
___ Psychiatric Care
___ Radiation Treatments
___ Recent Weight Loss
___ Rheumatism
___ Stomach/Intestinal Disease
___ Stroke
___ Thyroid Disease
___ Tuberculosis
___Tumors or Growths
___ Ulcer

Have you had any other serious illness not listed? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can result in serious health complications. It is my responsibility to inform Stefan Family Dental of any changes in my medical status.

_____ _____
Signature of Patient, Parent, or Guardian Date

_____
Doctor/Staff Signature