MEDICAL HISTORY

Advanced Dental Services Of Jacksonville

Date: _____

Name: _____ Date of Birth: _____ Age: _____
Last First Middle

Address: _____
Number & Street City State Zip

Phone: _____ Email: _____

In the following sections, please circle yes or no (whichever applies). Your answers are for our records and will be kept confidential.

Medical Information:

1) Overall, do you consider yourself to be in good general health? ..... YES NO

2) Have there been changes in your general health in the past year? ..... YES NO
If yes, explain:

3) Are you currently under the care of a physician? ..... YES NO
Physician Name(s):

Physician Contact Information:

4) Have you been hospitalized or had any serious illness or operation? ..... YES NO
If yes, explain:

5) Do you have or have you had any of the following medical conditions?

- Cardiovascular Disease (heart trouble, high blood pressure, heart attack, arteriosclerosis, etc.) ..... YES NO
- Congenital Heart Conditions ..... YES NO
- Rheumatic Fever or Rheumatic Heart Disease ..... YES NO
- Diabetes ..... YES NO
- Cancer ..... YES NO
- Chemotherapy or Radiation ..... YES NO
- Fainting Spells or Seizures ..... YES NO
- Bleeding Concerns ..... YES NO
- Blood Disorders (i.e. anemia, etc.) ..... YES NO
- Asthma ..... YES NO
- Kidney Disease ..... YES NO
- Liver Disease ..... YES NO
- Hepatitis ..... YES NO
- HIV Positive / AIDS ..... YES NO
- Tuberculosis (TB) ..... YES NO
- Arthritis or Inflammatory Rheumatism ..... YES NO
- Osteoporosis ..... YES NO
- Sinus Issues ..... YES NO
- Jaw Joint Clicking or Pain (TMJ) ..... YES NO
- Emotional or Psychiatric Problems ..... YES NO
- History of Alcohol or Drug Abuse/Addiction ..... YES NO

6) Do you have a disease, condition, or problem not listed above? ..... YES NO
If yes, explain:

7) Have you experienced abnormal bleeding with surgery, extractions, or trauma?
…….. YES NO

8) Do you any artificial heart valves or joints (including but not limited to hips, knees, shoulders, etc.)?..... YES NO

9) Have you had to take antibiotics prior to past dental visits for any other reason?
…….. YES NO

10) Have you had radiation treatment or surgery for a tumor, growth, cancer, or any other condition of head or neck?
…….. YES NO

11) Are you now taking/have you ever taken any of the following medications?

- Antibiotics
  …….. YES NO
- Anticoagulants (blood thinners), including Aspirin…….. YES NO
- Nitroglycerin
  …….. YES NO
- Steroid Medication (i.e. prednisone, cortisone, etc.) …….. YES NO
- Bisphosphonates (medications to build bone)…….. YES NO
- Insulin
  …….. YES NO

Female Patients Only:

- Are you/could you potentially be pregnant?…….. YES NO
- Are you currently breast-feeding?
  …….. YES NO
- Are you currently taking oral contraceptives (birth control)? …….. YES NO

Medications:
Please list all medications that you are currently taking (Prescription and Over The Counter):

Allergies:
Please list all known allergies. Please outline allergy and associated response.

I understand that, to the best of my knowledge, all of the preceding answers are true, accurate, and correct. If I ever have any change in my health or medications, I will inform my health care provider immediately. I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent, legal guardian, or foster parent) to Advanced Dental Services of Jacksonville.

Name (Print) Signature Date