Susanne Jackson, DDS, PA

Medical History

Patient Name: Birth Date:

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you take can impact your dental treatment.

Name of Physician (and phone # if available)	○ Yes ○ No	If yes
Have you ever been hospitalized, had any major operations, or had any serious illnesses?	○ Yes ○ No	If yes
Are you currently taking any medications or substances, including over-the-counter?	○ Yes ○ No	If yes
Have you ever taken bone-modifying medications (e.g. Fosamax, Zometa, Boniva, Actonel, Xgeva)?	○ Yes ○ No	If yes
Do you currently take an antibiotic premedication prior to dental treatment?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	

Women? Are you...

Pregnant (Include Due Date) ○ Yes ○ No	Trying to get pregnant ○ Yes ○ No	Nursing ○ Yes ○ No

Have you ever had an allergic reaction to any of the following?

☐ Penicillin	☐ Sulfa Drugs	☐ Aspirin/Tylenol/Advil
☐ Codeine	☐ Dental Anesthetic	☐ Latex

Other? ☐ If yes

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

AIDS/HIV	○ Yes ○ No	Diabetes	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Depression	○ Yes ○ No	Kidney Problems	○ Yes ○ No
Angina	○ Yes ○ No	Epilepsy or Seizure Disorder	○ Yes ○ No	Psychological Disorders	○ Yes ○ No
Atrial Fibrillation	○ Yes ○ No	Fainting or Dizzy Spells	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Heart Attack	○ Yes ○ No	Sinus Problems	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Sleep Disorder	○ Yes ○ No
Asthma	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Stomach/Intestinal Disorder	○ Yes ○ No
Blood Disorders	○ Yes ○ No	Hepatitis/Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Cancer	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Tuberculosis (TB)	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Infective Endocarditis	○ Yes ○ No	Tumors	○ Yes ○ No

Have you ever had any other serious illnesses or conditions 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 to medical status.

Signature of Patient, Parent or Guardian:

X Date:_____