Westwood Dental Partners Medical History

Patient Name: Birth Date: Date Created:

Physician, Pharmacy, Emergency Contact

Physician's Name:	Yes No	If yes	
Physician's Phone Number	Yes No	If yes	
Emergency Contact's Name/ Number:	Yes No	If yes	
Preferred Pharmacy:	Yes No	If yes	
Pharmacy Phone Number:	Yes No	If yes	

Do you require premedication with antibiotics for your visits? If Yes, state reason, and what drug	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Have you been hospitalized or had a major operation in the LAST 2 YEARS?	Yes No	If yes	
Do you use tobacco/drugs?	Yes No	If yes	

ALLERGIES

I am allergic to the following:

None	Yes No	Latex	Yes No	Penicillin	Yes No	Ibuprofen	Yes No
Codeine	Yes No	Local Anesthetic	Yes No	Gluten	Yes No	Nuts	Yes No

Other Allergies Not Listed Above:

Medications I am currently taking:

I HAVE, OR HAVE HAD THE FOLLOWING CONDITIONS:

AIDS/ HIV Positive	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No	Dementia	Yes No
Diabetes	Yes No	Hepatitis A	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No
Renal Dialysis	Yes No	Anemia	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/ Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Shingles	Yes No	Artificial Joint	Yes No
Hypoglycemia	Yes No	Sickle Cell Disease	Yes No	Asthma	Yes No	Fainting Spells/Dizziness	Yes No
Irregular Heartbeat	Yes No	Sinus Trouble	Yes No	Blood Disease	Yes No	Kidney Problems	Yes No
Leukemia	Yes No	GERD	Yes No	Breathing Problems	Yes No	Frequent Headaches	Yes No
Liver Disease	Yes No	Stroke	Yes No	Bruise Easily	Yes No	Low Blood Pressure	Yes No
Cancer	Yes No	Glaucoma	Yes No	Thyroid Disease	Yes No	Chemotherapy	Yes No
Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No	Chest Pains	Yes No
Heart Attack/ Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No
Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Congenital Heart Defect	Yes No	Heart Pacemaker	Yes No
Parathyroid Disease	Yes No	Ulcers	Yes No	Convulsions	Yes No	AFIB	Yes No

ANY OTHER HEALTH ISSUES WE HAVE MISSED: ☐ If yes

IF NEEDED, PLEASE EXPLAIN ANY OF THE ABOVE:

Women: Are you...

☐ Pregnant/Trying? ☐ Nursing? ☐ Taking Oral Contraceptives?

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:_____