Time 11:12 AM | Elizabeth G. Mitchell, DDS, LLC | Date 3/26/2018

The 901 Dentist Medical History

Patient Name: Birth Date: Date Created:

Question	Yes	No	If yes
Are you being treated by a physician for an ongoing condition?	◯ Yes	◯ No	If yes
Physician's Name and number	◯ Yes	◯ No	If yes
Have you had any major changes to your health in the last year?	◯ Yes	◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes	◯ No	If yes
Do you have COPD or any other form of breathing difficulty?	◯ Yes	◯ No	If yes
Are you the recipient of an organ transplant?	◯ Yes	◯ No	If yes
Do you take a blood thinner?	◯ Yes	◯ No	If yes
Do you have an artifical joint, if yes, please list joint and year of placement	◯ Yes	◯ No	If yes
Do you require Pre-Medication with antibiotics?	◯ Yes	◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes	◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes	◯ No	If yes
Are you Pregnant, Nursing, or taking oral contraceptives?	◯ Yes	◯ No	If yes
Do you use Tobacco?	◯ Yes	◯ No	If yes
Please list any medications you are taking, including over the counter and supplements (ex. Fish Oil)	◯ Yes	◯ No	If yes

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics
- ☐ Iodine

Do you have an allergy not listed above? ◯ Yes ◯ No If yes

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

Condition			Condition			Condition			Condition		
AIDS/HIV Positive	◯ Yes	◯ No	Cortisone Medicine	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No	Radiation Treatments	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	Anaphylaxis	◯ Yes	◯ No	Drug Addiction	◯ Yes	◯ No	Renal Dialysis	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No	Angina (Chest Pains)	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No
Rheumatism	◯ Yes	◯ No	Epilepsy or Seizures	◯ 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/Dizziness/Vertigo	◯ Yes	◯ No	Blood Disease	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Breathing Problems	◯ Yes	◯ No	Headaches	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No
Stroke	◯ Yes	◯ No	Bruise Easily	◯ Yes	◯ No	Cancer	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No
Lung Disease	◯ Yes	◯ No	Thyroid Condition	◯ Yes	◯ No	Chemotherapy	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No
Tonsillitis	◯ Yes	◯ No	Heart Attack/Failure	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No	Cold Sores/Fever Blisters	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No	Tumors or Growths	◯ Yes	◯ No	Congenital Heart Disorder	◯ Yes	◯ No	Heart Pacemaker	◯ Yes	◯ No
Ulcers	◯ Yes	◯ No	Heart Trouble/Disease	◯ Yes	◯ No	Venereal Disease	◯ Yes	◯ No	Hepatitis A, B, or C	◯ Yes	◯ No
Mental Disorder	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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:___________

DR

Signature of Doctor:

X Date:___________