The Atlanta Center for Restorative Dentistry

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Print Form

Medical History

Name:		Date of Birth:		Gender:	

Primary Physician

Physician contact information		Please list any medications or substances you are taking, including vitamins and herbs.	
Date of last physical			

Allergies/Sensitivities

Please list any medications or substances to which you are allergic.		Please list any other allergies or hives.	

Are you sensitive to penicillin or other antibiotics?	◯ Yes ◯ No	Are you sensitive to any anesthetics?	◯ Yes ◯ No
Are you sensitive to any metals?	◯ Yes ◯ No	Are you sensitive to latex?	◯ Yes ◯ No

Pregnancy/Birth Control

Are you or could you be pregnant?	◯ Yes ◯ No	Do you use any birth control medications?	◯ Yes ◯ No

Heart Related Issues

Have you ever been treated for or told you might have heart disease? Explain.		Do you have a pacemaker?	◯ Yes ◯ No
		Do you have an artificial heart valve implant?	◯ Yes ◯ No
		Have you ever been diagnosed with mitral valve prolapse?	◯ Yes ◯ No
Have you ever had rheumatic fever?	◯ Yes ◯ No	Are you aware of any heart murmurs?	◯ Yes ◯ No
Do you have high blood pressure?	◯ Yes ◯ No	Do you have low blood pressure?	◯ Yes ◯ No
Have you taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?			◯ Yes ◯ No

Other Health Issues

Have you ever had radiation treatment?	◯ Yes ◯ No	Have you ever had chemotherapy?	◯ Yes ◯ No
Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis?	◯ Yes ◯ No	Do you have inflammatory diseases, such as arthritis or rheumatism?	◯ Yes ◯ No
		Do you have any artificial joints or prostheses?	◯ Yes ◯ No
Do you have any blood disorders, such as anemia, leukemia, etc.?	◯ Yes ◯ No	Have you ever bled excessively after being cut or injured?	◯ Yes ◯ No

Do you have any stomach problems?	◯ Yes ◯ No	Do you have any kidney problems?	◯ Yes ◯ No
Do you have any liver problems?	◯ Yes ◯ No	Are you diabetic?	◯ Yes ◯ No
Do you have fainting or dizzy spells?	◯ Yes ◯ No	Do you have asthma?	◯ Yes ◯ No
Have you tested HIV positive?	◯ Yes ◯ No	Do you have AIDS?	◯ Yes ◯ No
Have you had or do you test positive for hepatitis?	◯ Yes ◯ No	Do you or have you had T.B.?	◯ Yes ◯ No
Do you smoke, chew, use snuff or any other form of tobacco?	◯ Yes ◯ No	Do you regularly consume more than one or two alcoholic beverages a day?	◯ Yes ◯ No
Do you habitually use controlled substances?	◯ Yes ◯ Yes	Have you had psychiatric treatment?	◯ Yes ◯ No

Please tell us about any diseases or problems not covered above.	
Is there anything else we should know about your health?	

Would you like to speak to the Doctor privately about any problem?	◯ Yes ◯ No

I certify that the above information is complete and accurate.

Patient Signature:		**Date:**	
Dentist Signature:		**Date:**	