Mount Auburn Dental

# MEDICAL HISTORY

(Please use only black or blue pen to complete)

**NAME**_____ **DOB**_____

**ADDRESS**_____ **PHONE**_____

***Do you have any of the following drug allergies:***

*__Aspirin __ Latex __ Codeine __ Penicillin __ Anesthetic __ Antibiotics __Percodan __Erythromycin __ Sulfa*

*List any additional allergies:* _____

**Please check any that apply to you:** **DO YOU REQUIRE PRE-MEDICATION BEFORE A VISIT? ___ YES __ NO**

__ Heart Disease
__ Heart Surgery _____
__ Artificial Heart Valve
__ Stroke
__ Liver Disease – Hepatitis
__ Pacemaker
__ Other: _____
__ Mental Health Disorders

__ Artificial Joints
__ Cancer/Cancer Therapy
__ Tuberculosis
__ HIV/AIDS
__ Kidney Disease
__ Epilepsy/Seizures

__ High Blood Pressure
__ Diabetes
__ Asthma
__ Drug Use/Addiction
__ Smoker – how many/D _____
__ Birth Control
__ Pregnancy/ Nursing

Depression/anxiety/other (circle)_____

__ **NONE APPLY** Please use the back side of this form to elaborate on any checked conditions if needed.

List all medications you currently take, prescription and over-the-counter.
**Please include dosages. (If you have a medication list we can photocopy it.)**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**Please indicate any of the following drugs you have taken at any time:**

__ Fosamax ___ Didronel
___ Zometa ___ Aredia
___ Skelid ___ Actonel
____ Bisphosphonates

**Emergency Contact**_____ **Phone #**_____

**Relationship to you** _____

**Primary Physician**_____ **Phone #**_____

**Pharmacy** _____ **Pharmacy Location**_____

I certify the information recorded on this medical form is correct. I understand it is my responsibility to notify Mount Auburn Dental of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold Mount Auburn Dental or its employees liable in the event of injury or death.

_____ _____

**Signature** **Date**