Bell Dental Medical History

Patient Name: ______________________________ Date: ____/____/____

Medical History *(Please check any of the following that apply to you): YES/NO*☐☐

☐☐ AIDS/HIV	☐☐ Excessive Bleeding	☐☐ Liver Disease	☐☐ Stomach Problems
☐☐ Anemia	☐☐ Fainting	☐☐ Mental Disorders	☐☐ Stroke
☐☐ Arthritis	☐☐ Heart Problems	☐☐ Anxiety/Depression	☐☐ Tobacco User (*currently*)
☐☐ Asthma	☐☐ Heart Attack	☐☐ Pacemaker	☐☐ Tuberculosis
☐☐ Blood Disease	☐☐ Heart Disease	☐☐ Pregnant (*currently*)	☐☐ Tumors
☐☐ Blood Thinner	☐☐ Heart Failure	Due Date ____________	
☐☐ Cancer	☐☐ Hepatitis A B C	☐☐ Radiation Treatment	
☐☐ Diabetes: Type 1 Type 2	☐☐ High Blood Pressure	☐☐ Respiratory Problems	
☐☐ Dizziness	☐☐ Jaundice	☐☐ Sinus Problems	
☐☐ Epilepsy	☐☐ Kidney Disease	☐☐ Stent	

Please list any and all other conditions not mentioned above that you are being currently being treated for:

____

____

Allergies - Are you allergic to or have you had a reaction to *(Please check all that apply and list type of reaction)*:

- ☐ Local Anesthetics ______________________
- ☐ Aspirin ______________________
- ☐ Penicillin or other antibiotics______________________
- ☐ Sedatives/Sleeping pills______________________
- ☐ Sulfa Drugs ______________________
- ☐ Codeine or other narcotics______________________
- ☐ Metals ______________________
- ☐ Latex (*rubber*) ______________________
- ☐ Iodine______________________
- ☐ Hay Fever/Seasonal ______________________
- ☐ Animals ______________________
- ☐ Food ______________________
- ☐ Other (please list):______________________

Other Medical Information (*Please circle YES or No*):

- Have you had Joint Replacement? YES NO Date:____/____/____ Any Complications? YES NO Not Applicable
- Do You Require Pre-Medication Prior to any dental treatment? YES NO
- Are you taking or scheduled to begin taking Bisphosphonate medication (such as Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia, Aredia, Zometa, XGEVA)? YES NO
- Are you Currently under Pain Management or have a Pain Manager? YES NO
- Are you currently on any Blood Thinners (Coumadin, Warfarin, Clopidogril/Plavix, Xerelto, Eliquis)? YES NO

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (PRESCRIPTION AND OVER THE COUNTER)

Name of Medication	Dosage	Name of Medication	Dosage

Name of Family Doctor: ______________________________ Phone: ______________

Patient/Parent Signature: ______________________________ Date: ____/____/____

Doctor Signature: ______________________________ Date: ____/____/____