George Family Dentistry
Medical & Dental History

What is the date (or approximate date) of your last medical exam? _____

Who is primary care physician's name, address & phone number:

_____

_____

Are you allergic to any medications? _____Yes _____No

If yes, to what and what happens?

_____

Have you ever had complications following dental treatment? _____Yes _____No

If yes, what happened? _____

Are you currently under the care of a physician for a specific condition?

_____ Yes _____No

Tell us about that: _____

Have you been hospitalized within the last 12 months due to surgery or illness?
_____Yes _____No

If yes, please explain: _____

Do you have any artificial joints? _____Yes ____No

What was replaced? When? _____

Do you use tobacco products? _____Yes _____No

If yes, how many packs a day? _____

Do you drink alcohol? _____Yes _____No

If yes, how often? _____

Are you taking any prescription/non-prescription medications? _____Yes _____No

If yes, please list or provide us with a list: _____

_____

Are you (or could you be) pregnant? _____Yes _____No

Your due date? _____

(Continued on Back)

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Please indicate if have experienced any of the following:

_____Allergies-Environmental _____Arthritis _____Asthma

_____Back/Neck Problems _____Bariatric Surgery _____ Blood Disorder

_____Cancer/Radiation/Chemo _____High Cholesterol

_____Circulatory Problems _____Depression/Anxiety _____Diabetes

_____Dizziness/Vertigo _____Epilepsy/Seizures _____HIV/AIDS

_____Glaucoma/Eye Problem _____Headaches/Migraines

_____Heart/Aortic Stents _____High Blood Pressure _____Hepatitis

_____Kidney/Liver Disease _____Pacemaker/Defibrillator

_____Respiratory Problems _____Sinus Problems _____Latex Allergy

_____Stomach/Colon Problems/Ulcers _____Stroke

_____Thyroid Disease _____Tongue/Facial Piercing

_____Eating Disorder

Please provide any explanations to checked items above if needed:

_____

_____

The practice of dentistry involves the whole person. If the dentist determines that there may be a potential medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician. I will inform my dentist of any change in my health and/or medications. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____

Date: _____