Sierra Crest Dental
Medical History

Patient Name ____________________ Age ________

Name of Physician ____________________

Physician Phone ____________________ Date of last visit ____________________

Current Physical Health Poor ❒ Fair ❒ Good ❒

Do you use tobacco in any form? No ❒ Yes ❒ Kind ____________________

Surgeries ____________________

Current Medical Treatment ____________________

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List Medications ____________________

YES	NO	CONDITIONS
❒	❒	Abnormal Bleeding
❒	❒	Abnormal Growth/Tumor
❒	❒	Alcohol/Drug Dependency
❒	❒	Anemia
❒	❒	Arthritis
❒	❒	Asthma
❒	❒	Blood Pressure
		❒ High
		❒ Low
❒	❒	Cancer
❒	❒	Chemotheraphy
❒	❒	Cholestoral (High)
❒	❒	Cold Sores / Fever Blisters
❒	❒	Depression
❒	❒	Diabetes
❒	❒	Difficulty Breathing
❒	❒	Digestive Problem
❒	❒	Epilepsy/Seizures
❒	❒	Esophageal Reflux/GERD
❒	❒	Facial Surgery
❒	❒	Fainting
❒	❒	Glaucoma
❒	❒	Headaches
❒	❒	Head/Neck Injury

YES	NO	CONDITIONS
❒	❒	Heart
		❒ Attack
		❒ Congenital Defect
		❒ Pace Maker
		❒ Surgery
❒	❒	Hepatitis
		❒ A
		❒ B
		❒ C
❒	❒	HIV/AIDS
❒	❒	Hives/Rash/Hay/Fever
❒	❒	Joint Replacement
❒	❒	Kidney Disease
❒	❒	Liver Disease
❒	❒	Lumps in Mouth
❒	❒	Radiation Therapy
❒	❒	Seizures
❒	❒	Sinus Problems
❒	❒	Sleep Apnea
❒	❒	Snoring
❒	❒	STD
❒	❒	Stroke
❒	❒	Thyroid Problem
❒	❒	TB

YES	NO	CONDITIONS
ALLERGIES		
❒	❒	Asprin
❒	❒	Clindamycin
❒	❒	Dental Anesthetics
❒	❒	Floride
❒	❒	Hydrocodone/Codeine
❒	❒	Jewelry
❒	❒	Latex
❒	❒	Metals
❒	❒	Penicillin
❒	❒	Tetracycline
❒	❒	Other
		____________________
MALE		
❒	❒	Prostate Disorder
FEMALE		
❒	❒	Birth Control Pills
❒	❒	Pregnant
❒	❒	Bisphosphonates

Please advise us in the future of any change in your medical history or any medications you may be taking.

Patient's Signature ____________________ Date ____________

Doctor's Signature ____________________