Malcomson
DENTISTRY

Patient Medical History

Patient's Name: _____ **Approx. Date of LAST Physical:** ____/____/____

Primary Care Physician: **Dr.** _____ Phone Number: (_____)_____

Pharmacy & Location: _____ Phone Number: (_____)_____

1. Are you currently under medical care? *If yes, please specify:* _____ Y N
2. List **ALL** medications (prescription, non-prescription, homeopathic/herbal supplements *and* recreational drugs) _____ Y N
   _____
3. Have you had surgery (joint, cosmetic, etc.) in the last **5 years,** a serious illness or significant weight loss? *If yes, please specify:* _____ Y N
4. Have you ever taken *(circle)*: Fen-Phen / Dexfenfluramine / Bisphosphonates? Y N
5. Do you currently use (circle): chewing tobacco / smoke / vape / e-cigarettes? Y N
6. **Women ONLY (circle):** Are you pregnant or think you may be pregnant or breast feeding? Y N
   Are you using any form of oral or implanted contraception? Y N

Y	N	Allergies / Hay Fever	Y	N	Artificial Bones	Y	N	Diabetes
Y	N	Sinus Problems	**Y**	**N**	**Artificial Joint Replacement**	Y	N	Sickle Cell Disease
Y	N	Asthma	**Y**	**N**	**Other Implant:_____**	Y	N	Kidney / Bladder Disease
Y	**N**	**Respiratory Disease / COPD**	Y	N	Angina Pectoris	Y	N	Liver Disease / Jaundice
Y	**N**	**Pneumocystitis**	Y	N	Congenital Heart Defect	Y	N	Shingles
Y	N	Emphysema	Y	N	Heart Murmur	Y	N	Cortizone / Steroid Therapy
Y	N	Tuberculosis	Y	N	Heart Attack	**Y**	**N**	**Thyroid Problems**
Y	N	Acid Reflux / Ulcer	**Y**	**N**	**Cardiac Incident / Pacemaker / Atrial Fibrillation**	Y	N	Psychiatric Care
Y	N	Arthritis / Rheumatism				Y	N	Alcohol Dependency
Y	N	Back Problems	**Y**	**N**	**Artificial Heart Valve**	Y	N	**Drug / Substance / Chemical Dependency**
Y	N	**Osteoporosis**, list medication:_____	Y	N	Heart Valve Replacement	Y	N	Hepatitis: _____
			Y	N	Mitral Valve Prolapse	Y	N	STI(s):_ _____
Y	**N**	**Cancer Treatment: Chemo / Radiation Therapy**	Y	N	Stroke	Y	N	**Immune System Disorder: AIDS / HIV / ARC**
Y	N	**HIGH** Blood Pressure	Y	N	Circulatory Problems			
Y	N	**LOW** Blood Pressure	Y	N	Edema / Swelling of Ankles or Feet			
Y	N	Fainting Spells	Y	N	Colitis / IBS			
Y	N	Rheumatic Fever	Y	N	Epilepsy			
Y	N	Anemia	Y	N	Seizures			
Y	N	Abnormal Bleeding	Y	N	Contact Lenses			
Y	N	Hemophilia	Y	N	Glaucoma			
Y	N	Blood Transfusion	Y	N	Headaches / Migraines			

List or Circle ALL other Allergies:
Antibiotics Aspirin, Codeine, Dental Anesthetics, Erythromycin, Jewelry, Latex, Local Anesthesia, Metals, Penicillin, Sulfa drugs Tetracycline?
_____

I attest to the best of my knowledge, that I have honestly answered the above medical questions. I understand that providing incorrect or misinformation can be dangerous to my health. Dr. E. Denise Malcomson and Malcomson Dentistry staff will not be responsible for errors and omissions, that I have made on this form.

Patient or Guardian's Signature: _____ **Date:** _____/_____/_____

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