Gilford Dental

MEDICAL HISTORY FORM

Patient Name: (Last, First) DeLorenzo Marc **Date of Birth:** 04/30/1993

Name of Primary Care Provider: _____ **Last visit date:** _____

Please answer the following questions If YES, please explain	Y	N	
Have you ever been hospitalized or had a major operation?	☐	☐	
Have you ever had a serious head or neck injury?	☐	☐	
Do you take blood thinning medications (i.e Warfarin/Coumadin,Heparin, Plavix,Eloquis)?	☐	☐	
Have you ever taken bisphosphonates (to strengthen bones) such as Fosamax, Boniva, Actonel?	☐	☐	
Do you take a Pre-med before your dental appointments? If YES, please explain why:	☐	☐	
Do you use tobacco? If YES, how much:	☐	☐	
Do you use controlled substances? If YES, please list:	☐	☐	

List All Medications, including Over-the-Counter and Homeopathic:

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Females: Are you.. Pregnant/Trying to get pregnant? ☐ Y ☐ N Taking oral contraceptives? ☐ Y ☐ N Nursing? ☐ Y ☐ N

Are you allergic to any of the following? Check ALL that apply. ☐ If you have No Known Allergies, please check here

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metals ☐ Latex ☐ Sulfa Drugs ☐ Nuts

Please list any other allergies NOT listed above: _____

Do you have, or have you had, any of the following? **Please ONLY check boxes next to medical conditions that are relevant to you:**

Aids/HIV ☐	Congenital Heart Disorder ☐	Heart Trouble/Disease ☐	Radiation Treatments ☐
Alzheimer's Disease ☐	Convulsions ☐	Hemophilia ☐	Recent Weight Loss ☐
Anaphylaxis ☐	Cortisone Medicine ☐	Hepatitis A ☐	Renal Dialysis ☐
Anemia ☐	Diabetes ☐	Hepatitis B or C ☐	Rheumatic/Scarlet Fever ☐
Angina/Chest Pains ☐	Drug Addiction ☐	Herpes ☐	Rheumatism ☐
Anxiety and/or Depression ☐	Easily Winded ☐	High Blood Pressure ☐	Shingles ☐
Arthritis ☐	Emphysema ☐	Hives or Rash ☐	Sickle Cell Disease ☐
Artificial Heart Valve ☐	Epilepsy or Seizures ☐	Hypoglycemia ☐	Sinus Trouble ☐
Artificial Joint ☐	Excessive Bleeding ☐	Irregular Heartbeat ☐	Stomach/Intestinal Disease ☐
Asthma ☐	Excessive Thirst ☐	Kidney Problems ☐	Stroke ☐
Autoimmune Disorder ☐	Fainting Spells/Dizziness ☐	Leukemia ☐	Swelling of Limbs ☐
Blood Disease ☐	Frequent Cough ☐	Liver Disease ☐	Thyroid Disease ☐
Blood Transfusion ☐	Frequent Headaches ☐	Low Blood Pressure ☐	Tonsillitis ☐
Breathing Problems ☐	Gout ☐	Lung Disease ☐	Tuberculosis ☐
Bruise Easily ☐	Hay Fever ☐	Mitral Valve Prolapse ☐	Tumors or Growths ☐
Cancer ☐	Heart Attack/Failure ☐	Osteoporosis ☐	Ulcers ☐
Chemotherapy ☐	Heart Murmur ☐	Pain in Jaw Joints ☐	Yellow Jaundice ☐
Cold Sores/Fever Blisters ☐	Heart Pacemaker ☐	Psychiatric Care ☐	

Have you ever had any serious illness NOT listed above? If YES, please explain: ☐ Yes ☐ No

_____

☐ **I have read my History and confirm that it adequately reflects past and present conditions.**

Sign here if form was printed_____ Date: ____/____/_____

_____ **Date:** 09/04/2024

Authorized signature of covered person (For minor, Parent or Guardian)