Indy Dental Group®
Comprehensive, Cosmetic & Family Dentistry
www.indydentalgroup.com

MEDICAL HISTORY

Patient Name:_____ **Date of Birth:**_____

MEDICAL HISTORY: Physician's Name _____Phone_____ Date of Last Visit_____

□ **YES** □ **NO** *Have you ever taken **"Antibiotic Pre-Medication"** prior to a dental appointment?
□ **YES** □ **NO** **Women: Are you Pregnant / or trying?** Due Date:_____Breast Feeding: □ YES □ NO
□ **YES** □ **NO** Are you currently taking **Blood Thinner** Medication?
□ **YES** □ **NO** Are you currently under medical care? If YES, please describe_____
□ **YES** □ **NO** Have you had any serious illnesses or surgeries? If YES, please describe_____
□ **YES** □ **NO** Have you ever had a blood transfusion? If YES, please give approximate dates_____
□ **YES** □ **NO** Taking Birth Control Pills? **Antibiotics may interfere with effectiveness of oral contraceptives*
□ **YES** □ **NO** *Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen"?
(These include combinations of Ionimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine).
□ **YES** □ **NO** *Have you ever taken Bisphosphonates (i.e. Fosamax, Boniva, Zometa/Reclast, Actonel, Aredia, Didronel, Skelid)?
□ **YES** □ **NO** *Do you **Smoke / Vape** or use smokeless tobacco? If YES, how many cigarettes (pipe, cigar, VAPING) per day_____How many years_____

Check (√) if you now have or have ever had the following:

HEART / CIRCULATORY
□ Heart Problems
□ High Cholesterol
□ Heart Attack
□ Heart Surgery
□ Heart Stents
□ Congestive Heart Failure
□ Heart Murmur
□ Pacemaker / Defibrillator
□ Congenital Heart Problems
□ Rheumatic Fever
□ Mitral Valve Prolapse
□ Artificial Heart Valves
□ High □ Low Blood Pressure
□ Fainting / Dizzy Spells
□ Stroke

RESPIRATORY
□ Asthma
□ COPD
□ Cough, Chronic, Persistent
□ Coughing Up Blood
□ Tuberculosis
□ Emphysema
□ Smoke Cigarettes □ Pipe □ Cigar
□ Vaping □ Marijuana /Pot

BLOOD DISORDERS
□ Anemia
□ Hemophilia
□ Bruise Easily
□ Petechia – "Pin" Size Bruising
□ Sickle Cell Disease
□ Taking/On Blood Thinner Medicine

ORTHOPEDICS / TRAUMA
□ Artificial Joints □ Pre-medicate?
□ Arthritis, Osteoporosis
□ Arthritis, Rheumatoid
□ Trauma - Teeth
□ Trauma – Head/ Neck/ Face
□ Cosmetic Surgery Face/Neck
□ Cortisone Medicine / Treatment

INFECTIOUS
□ Hepatitis □ Hep A □ Hep B □ Hep C
□ AIDS □ HIV Positive
□ Shingles
□ Sexually Transmitted Disease
□ Cold Sores
□ MRSA (Methicillin Resistant STAPH Aureus)

OTHER
□ please describe_____
□ Diabetes □ Type I □ Type II
□ Kidney Problems □ Renal Dialysis
□ Thyroid Problems
□ Ulcers □GERD □ Acid Reflux
□ Sinus Problems
□ Epilepsy □Seizures
□ Glaucoma
□ Alzheimer's Disease
□ Cancer □Chemotherapy □Radiation
□ Psychiatric Care
□ Anxiety □Depression
□ Alcohol □ Drug Addiction
□ Recreational Drug Use

ALLERGIES: List All	**Current Medications: List All** (pt provided attached list □ YES □ NO)
□ Latex □ Local Anesthetics □ Penicillin □ Sulfa □ Codeine □Other	

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect or outdated information can be dangerous to my health and safety. It is my responsibility to inform this dental practice of any/all changes in my medical and dental health history. I authorize the Dentist to perform any and all forms of treatment, medication, and therapy that may be required. I further authorize the Dentist to choose and employ assistance as needed.

_____Date_____
Signature of Patient, Parent, or Legal Guardian

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