Broadway Smiles
EXCEPTIONAL DENTISTRY

MEDICAL HISTORY

Are you taking any of the following medications?

- ☐ Stimulants
- ☐ Pain Killers (Including Aspirin)
- ☐ Muscle Relaxers
- ☐ Bisphosphonates
- ☐ High Blood Pressure Pills
- ☐ Blood Thinners
- ☐ Tranquilizers
- ☐ Insulin

Other(s), please list: _____

Have you had or do you have any of the following medical conditions?

High/Low Blood Pressure	☐Y ☐N	Stroke	☐Y ☐N	Arthritis/Gout	☐Y ☐N
Heart Murmir	☐Y ☐N	Kidney Disease	☐Y ☐N	Detached Retina/Glaucoma	☐Y ☐N
Mitral Valve Prolapse	☐Y ☐N	Diabetes	☐Y ☐N	Auto-Immune Disease	☐Y ☐N
Pacemaker	☐Y ☐N	Hypoglycemia	☐Y ☐N	AIDS (HIV)	☐Y ☐N
Heart Attack/Surgery	☐Y ☐N	Liver Disease/Jaundice	☐Y ☐N	Cold Sores (lip)	☐Y ☐N
Rheumatic Fever	☐Y ☐N	Seasonal Allergies	☐Y ☐N	Gastroesophageal Reflux	☐Y ☐N
Congestive Heart Failure	☐Y ☐N	Sinus/Nasal Problems	☐Y ☐N	Cancer	☐Y ☐N
Chest Pain/Angina	☐Y ☐N	Asthma	☐Y ☐N	Radiation Treatment	☐Y ☐N
Artificial Heart Valve	☐Y ☐N	Lung Disease	☐Y ☐N	Chermotherapy	☐Y ☐N
Artificail Joints/Hip	☐Y ☐N	Tuberculosis	☐Y ☐N	Osteoporosis	☐Y ☐N
Anemia	☐Y ☐N	Chronic Cough	☐Y ☐N	MRSA	☐Y ☐N
Bleeding or Clotting Disorder	☐Y ☐N	Sleep Apnea (CPAP)	☐Y ☐N	Psychiatric Care	☐Y ☐N
Fainting or Dizziness	☐Y ☐N	Hepatitis A or B or C	☐Y ☐N	Celiac Disease	☐Y ☐N
Epilepsy or Seizures	☐Y ☐N	Thyroid Disease/Goiter	☐Y ☐N	Other	☐Y ☐N
Multiple Selerosis	☐Y ☐N	Sjogren's Disease	☐Y ☐N		

Are you allergic to any of the following?

Penicillin	☐Y ☐N	Local Anesthetic	☐Y ☐N
Codeine	☐Y ☐N	Sedative	☐Y ☐N
Sulfa	☐Y ☐N	Aspirin	☐Y ☐N
Latex	☐Y ☐N	Ibuprofen	☐Y ☐N
Iodine	☐Y ☐N	Shellfish	☐Y ☐N

Please List Other Allergies

_____

_____

_____

_____

Chemical Dependency

Smoking (any form)	☐Y ☐N
Chewing Tobacco	☐Y ☐N
History of Alcohol or Drug Dependency?	☐Y ☐N

Women

Are you taking Birth Control? ☐Yes ☐No

If YES what type? ☐Pills ☐Shots ☐Patch ☐Norplant

Are you pregnant? ☐Yes ☐No

Are you nursing? ☐Yes ☐No

Are you taking hormone replacements? (HRT) ☐Yes ☐No

With regards to oral contraceptives it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is complete. Please consult with you physician for further guidance.

Signature of Patient or Parent If Minor **Date**

- We invite you to discuss with us any questions regarding our services. The best Dental Health Services are based on a mutual understanding between provider and patient.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature of Patient or Parent If Minor **Date**