AGAVE DENTAL
Smile Esthetics and Wellness

MEDICAL HISTORY

Patient Name:_____ DoB: ____/____/____

Name of Primary Care Physician: _____ Phone: ____-____-____

Other physicians:

_____

Do you now have or have you ever had any of the following medical conditions? Mark with √

- ☐ Heart Disease / Defect
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ Angina / Chest Pain
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Blood Disease
- ☐ Stroke
- ☐ Bruise Easily
- ☐ Anemia
- ☐ Excessive Bleeding
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Allergies (Seasonal)
- ☐ Pain in the Jaw
- ☐ Lung Disease
- ☐ Breathing Problems
- ☐ Tuberculosis (TB)
- ☐ Sinus Problems
- ☐ Asthma – type:_____
- ☐ Emphysema
- ☐ Thyroid Disease
- ☐ Fainting / Dizziness
- ☐ Cancer
- ☐ Radiation Treatment
- ☐ Chemotherapy
- ☐ Artificial Joint:_____
- ☐ AIDS / HIV Positive
- ☐ Autoimmune Disease:_____
- ☐ Osteoporosis / Osteopenia
- ☐ Stomach / Intestinal Disease
- ☐ Ulcers
- ☐ Convulsions / Seizures
- ☐ Epilepsy
- ☐ Diabetes – type:_____
- ☐ Hypoglycemia
- ☐ Liver Disease
- ☐ Hepatitis – type:_____
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Arthritis – type:_____
- ☐ Drug Use / Addiction
- ☐ Alcohol Addiction
- ☐ Cold Sores / Fever Blisters
- ☐ Nervousness
- ☐ Depression
- ☐ Other:_____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry/Metals
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other:_____

- ☐ Have you been hospitalized or had any major operations?_____
- ☐ Have you ever taken Boniva, Fosamax, or Alendronate?_____
- ☐ Do you smoke or use tobacco (how much/frequency)?_____
- ☐ Are you taking any prescription or over-the-counter drugs?

Please list each one:

Medication	Dosage	Reason for Taking Medication

Women only: Are you currently:

- ☐ Pregnant
- ☐ Nursing
- ☐ Taking Birth Control Pills

_____ _____

Patient Signature Date