Medical History

Answers to these questions help us provide safe and effective dental care personalized to your individual needs.
All information is kept strictly confidential.

Have you taken any prescription drugs during the last 6 months? ? ☐ Yes ☐ No

If yes, please list: _____

_____

Are you taking any over the counter medications or herbal supplements? ☐ Yes ☐ No

If yes, please list: _____

Are you allergic to (i.e. itching, rash, swelling of hands, feet, eyes) or made sick by any medication? ☐ Yes ☐ No

If yes, please list: _____

Any surgeries and/or hospitalizations? ☐ Yes ☐ No

If yes, please list: _____

Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No

If yes, please list: _____

Have you ever taken drugs by mouth or by injection to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget's disease, breast or prostate cancer? ☐ Yes ☐ No

If yes, please list: _____

Have you ever been told to take antibiotics prior to dental treatment? ☐ Yes ☐ No

If yes, please list: _____

Use of alcohol: ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly Use of recreational drugs: ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No What type and how much per day? _____

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE AT THE PRESENT OR HAVE HAD IN THE PAST:

☐ Low Blood Pressure	☐ Kidney Problems	☐ Seizures/Epilepsy	☐ Leukemia
☐ High Blood Pressure	☐ Sexually Transmitted Diseases	☐ Allergies/Sinus Trouble	☐ Bruise/Bleed Easily
☐ Heart Disease/Attack	☐ Acid Reflux	☐ Asthma/Bronchitis	☐ Osteoporosis
☐ Angina Pectoris	☐ Ulcers	☐ Emphysema/COPD	☐ Arthritis
☐ Artificial Heart Valve	☐ Liver Failure	☐ Chemotherapy	☐ Joint Replacements
☐ Heart Failure	☐ Hepatitis/Jaundice	☐ Radiation Treatment	☐ Sleep Apnea
☐ Heart Pacemaker	☐ Diabetes Type I or II	☐ HIV/AIDS	☐ Excessive Daytime Sleepiness
☐ Stroke	☐ Thyroid/Gland Problems	☐ Anemia	

Are you pregnant now? ☐ Yes ☐ No **Practicing birth control?** ☐ Yes ☐ No **Plan to become pregnant?** ☐ Yes ☐ No

Emergency Contact: _____ Relation: _____ Emergency Phone: _____

PLEASE READ THE FOLLOWING CAREFULLY: To the best of my knowledge all of the preceding answers are true and correct, If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetic or pre-medications which may be deemed advisable.

_____ _____

Patient or Parent/Guardian Signature *Date*

SMILE DESIGN STUDIO
for the health...for the beauty...of your smile

1331 S. International Pkwy., Suite 2271, Lake Mary FL 32746
www.smilesbydrfalco.com • **407-804-0770** • office@smilesbydrfalco.com