DAVID S. AMID, D.D.S.

MEDICAL/DENTAL HISTORY

First Name_____ Last Name_____ Age_____

Do your gums bleed: Yes / No

Are your teeth loose? Yes / No

Are your teeth sensitive to? Sweets Cold Heat Pressure (Circle any that pertain to you)

Have you ever had any pain, clicking or popping in your jaw joints? Yes / No

Are you currently having a dental concern? Yes / No If yes, please explain _____

Do you use tobacco of any kind? Yes / No If yes, what is your daily average_____

Do you have an allergy to latex? Yes / No

Other Allergies? Yes / No If yes, please list below

Please list any MEDICINE ALLERGIES AND REACTIONS you have had:

Medication	Reaction	Medication	Reaction

DO YOU HAVE A HISTORY OF:

Artificial Joints/Valves	Yes / No	Heart Attack/Surgery	Yes / No	Hepatitis	Yes / No
Abnormal bleeding	Yes / No	Heart Murmur	Yes / No	Diabetes	Yes / No
Asthma/Difficulty breathing	Yes / No	Tuberculosis	Yes / No	Stroke	Yes / No
High Blood pressure	Yes / No	Kidney Disease	Yes / No	Liver Disease	Yes / No
AIDS or HIV positive	Yes / No	Hip or Knee Replacement	Yes / No		

Does your physician recommend antibiotic premedication for dental treatment? Yes / No If yes, please list_____

Have you ever taken Bisphosphonate medication (Fosamax, Actonel, Boniva)? Yes / No

Please list any MEDICATION(S), INCLUDING OVER-THE-COUNTER DRUGS, you currently take:

Medication	Purpose	Medication	Purpose

(Continued on other side)

Do you have a personal physician? Yes / No

Physician's Name: _____

Phone#: _____Date of last visit: _____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature_____Date_____

If you have completed this form for another person, please print your name and sign below along with your relationship to patient.

Print_____Relationship_____

Signature_____Date_____

OFFICE USE ONLY

Health History Update: On a regular basis, we will be asking about any changes in your medical history

Date	Changes/Comments	Signature of Patient and Provider
_____/_____/_____	_____	_____
_____/_____/_____	_____	_____
_____/_____/_____	_____	_____
_____/_____/_____	_____	_____
_____/_____/_____	_____	_____
_____/_____/_____	_____	_____