

David Langer DMD

Medical History Form

Patient Name: _____

Today's date: _____

Allergies: (Please Circle Yes or No)

Aspirin	Yes	No	Latex	Yes	No
Barbiturates/sedatives	Yes	No	Local anesthetics	Yes	No
Codeine/narcotics	Yes	No	Metals	Yes	No
Ibuprofen	Yes	No	Penicillin	Yes	No
Iodine	Yes	No	Sulfa	Yes	No

Any other allergies not listed above:

Medications and Controlled Substances

* Have you ever taken or undergone any of the following? (Please circle all that apply)

Blood Thinners Chemo/Radiation Osteoporosis/Cancer medication

(Such as Fosamax, Actonel, Reclast, Prolia, Eliquis, Warfarin, Xarelto, Pradaxa, Plavix)

Please list any other prescription medications or substances you currently take:

*Do you **smoke** or use **chewing tobacco**? If so how often and how long have you _____

Women ONLY: Are you? (Circle Yes or No)

For Dentist use ONLY:

Taking birth control pills: Yes No

Notes:

Pregnant: Yes No If yes, when are you due? _____

Nursing: Yes No If yes, how many weeks? _____

Please flip to the back ----->

Medical Conditions:

Have you had any joint replacement, heart surgery, or transplant surgery? Yes No

If so, what and when _____

(Please circle Yes or No)

AIDS/HIV	Yes	No	Heart murmur	Yes	No	Mitral valve prolapse	Yes	No
Alzheimer's	Yes	No	Heart disease	Yes	No	Osteoporosis	Yes	No
Anaphylaxis	Yes	No	Hemophilia	Yes	No	Psychiatric care	Yes	No
Anemia	Yes	No	Hepatitis A	Yes	No	Renal Dialysis	Yes	No
Arthritis	Yes	No	Hepatitis B/C	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Herpes or STDs	Yes	No	Rheumatism	Yes	No
Blood issues	Yes	No	High Blood pressure	Yes	No	Scarlet fever	Yes	No
Cancer	Yes	No	High cholesterol	Yes	No	Shingles	Yes	No
Diabetes	Yes	No	Hives	Yes	No	Sickle Cell disease	Yes	No
Drug addiction	Yes	No	Hypoglycemia	Yes	No	Stomach Disease	Yes	No
Emphysema	Yes	No	Irregular heartbeat	Yes	No	Stroke	Yes	No
Epilepsy	Yes	No	Kidney problems	Yes	No	Thyroid Disease	Yes	No
Fainting	Yes	No	Liver problems	Yes	No	Tonsillitis	Yes	No
Genital herpes	Yes	No	Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Glaucoma	Yes	No	Lung disease	Yes	No	Tumor or ulcers	Yes	No
Heart failure	Yes	No	Mental health concerns/conditions	Yes	No	Yellow Jaundice	Yes	No

If you have a condition not listed above, please write it here: _____

I understand the importance of complete and truthful medical/dental information and that any incorrect information could pose a serious threat to my health. To the best of my knowledge, the answers to the preceding questions are true and correct. I will not hold David Langer, DMD or any person who provides my dental services responsible for any actions that they take or do not take because of any errors or omissions that I may have made in the completion of this form. Further, if I have any change in my health or if my medications change, I will inform my hygienist or dentist at my next appointment.

Signature of Patient/Legal Guardian

Signature of Dr. Langer

Date