Galleria Dentistry
9140 Galleria Court
Naples, FL 34109-4343

www.galleriadentistry.com
(239)592-5112
info@galleriadentistry.com

MEDICAL HISTORY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

If there have been any changes in your health within the last year please explain.

Name of your Physician

If you have you ever been hospitalized or had a major operation please explain.

If you have had a Joint Replacement, date and name of doctor.

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

◯ Yes ◯ No

Please list all medications and over the counter drugs.

Have you been diagnosed with Sleep Apnea?

◯ Yes ◯ No

Do you use tobacco?

◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Taking oral contraceptives?

☐ Nursing?

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Are you allergic to any of the following?

- ☐ Asprin
- ☐ Penicillin
- ☐ Codeine
- ☐ Local Anesthetics
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs

Other Allergies

Do you have, or have you had any of the following?

- ☐ AIDS/ HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Arthritis/ Gout
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addicition
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/ Dizziness
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmer
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ MVP
- ☐ New Heart Valve
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickel Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors/ Growths

Have you ever had any serious illness not listed above?

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If you have to Premedicate for dental treatment, Did you take your antibiotics today?

◯ Yes ◯ No

What antibiotic did you take today?

To the best of my knowledge, the questions to this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I am giving my consent for routine dental procedures such as x-rays, cleaning, fillings, crowns and any local anesthetic by signing below.

Signature: _____ Date:

Response Date: