Cooper Dental Medical History updated 1/2016 (Copy)

Patient Name: Birth Date: Date Created:

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Are you Currently taking any medications or supplements?	Yes No	If yes	
Who prescribes these medications?	Yes No	If yes	
What pharmacy or pharmacies do you use?	Yes No	If yes	
Have you been hospitalized or had surgery in the past year?	Yes No	If yes	
Have you been diagnosed with sleep apnea?	Yes No	If yes	
Do you, or have you, had cancer? When and what type?	Yes No	If yes	

Did you undergo any of the following?

☐ Chemotherapy ☐ Radiation ☐ Surgery

Are you current on your vaccinations?	Yes No	If yes	
Do you have a history of taking Bisphosphonate drugs?	Yes No	If yes	
Do you use tobacco?	Yes No	If yes	
Do you drink alcohol? How many drinks per day?	Yes No	If yes	
Are you on a special diet?	Yes No	If yes	
Do you use controlled substances?	Yes No	If yes	
Are you pregnant? When is your due date?	Yes No	If yes	
Are you actively trying to get pregnant?	Yes No	If yes	
Are you taking oral contraceptives?	Yes No	If yes	
Are you allergic to antibiotics?	Yes No	If yes	

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Latex ☐ Acrylic

☐ Metal ☐ Local Anesthetics

Other allergies?	Yes No	If yes	

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

High Blood Pressure	Yes No	Cong. Heart Defect	Yes No	Kidney Disease	Yes No	Glaucoma	Yes No
Low Blood Pressure	Yes No	Irregular Heartbeat	Yes No	Dialysis	Yes No	Alzheimers	Yes No
High Cholesterol	Yes No	Arythmia	Yes No	Kidney Stones	Yes No	Parkinson's	Yes No
High Triglycerides	Yes No	Pacemaker	Yes No	Liver Disease	Yes No	Skin Disease	Yes No
Diabetes	Yes No	Blood Clots	Yes No	Pancreatitis	Yes No	Shingles	Yes No
Hypoglycemia	Yes No	Aneurysm	Yes No	Ulcers	Yes No	Cold Sores	Yes No
Artificial Joint	Yes No	COPD	Yes No	Crohn's Disease/IBS	Yes No	HIV	Yes No
Gout	Yes No	Tuberculosis	Yes No	GERD	Yes No	AIDS	Yes No
Epilepsy	Yes No	Emphysema	Yes No	Acid Reflux	Yes No	HPV	Yes No
Convulsions	Yes No	Asthma	Yes No	Weight Loss Surgery	Yes No	Other STD's	Yes No
Dizziness	Yes No	Pneumonia	Yes No	Shogren's	Yes No	Hepatitis A,B,C	Yes No
Vertigo	Yes No	Bronchitis	Yes No	Fibromyalgia	Yes No	ADHD	Yes No
Heart Attack	Yes No	Thyroid Disease	Yes No	Lupus	Yes No	Bipolar Disorder	Yes No
Heart Disease	Yes No	Anemia	Yes No	Rheumatoid Arthritis	Yes No	Depression	Yes No
Artificial Heart Valve	Yes No	Sickle Cell Anemia	Yes No	Arthritis	Yes No	Anxiety	Yes No
Frequent Chest Pain	Yes No	Hemophilia	Yes No	Hearing Loss	Yes No	Drug Addiction	Yes No
Angina	Yes No	Osteoporosis	Yes No	Vision Loss	Yes No	Alcoholism	Yes No

Do you any other illness not listed above?	Yes No	If yes	

To the best of my knowledge, the questions on this form have been accurately and truthfully answered. I understand that providing incorrect information can be dangerous to my (or other patient's) health. It is my responsibility to inform Cooper Dental of any changes in my medical status.

Signature of Patient, Parent or Guardian:

X Date:_____