Medical History con't

Medications routinely used in dental treatment may interact with both prescription and a number of illegal street drugs. Fill in the medications you are presently taking, medications you have taken in the past, or medications you have had adverse reaction to

Please use the example belop to provide us with information of your medication usage

Presently Taking ○ **Taken in the Past** ○ **History of Reation** ○ **Never Taken** ◉

Anesthetics, locally injected ○ ○ ○ ◉

Anesthetics, General ○ ○ ○ ◉

Antacids ○ ○ ○ ◉

Anti-Anxiety ○ ○ ○ ◉

Antidepressants ○ ○ ○ ◉

Antihistamines ○ ○ ○ ◉

Daily Aspirin Regimen ○ ○ ○ ◉

Birth Control ○ ○ ○ ◉

Blood Pressure ○ ○ ○ ◉

Codeine, Demerol or other Analgesics ○ ○ ○ ◉

Cortisone or other Steroids ○ ○ ○ ◉

Coumadin, Heparin,Warfarin or others ○ ○ ○ ◉

Dilantin ○ ○ ○ ◉

Diuretics (water pills) ○ ○ ○ ◉

Fen-phen (Lonimin, Adipex, Fastin, Phentermine, Pondimin, Fenfluramine, Redux) ○ ○ ○ ◉

Heart Medications such as Digoxin, Nitroglycerin, or Digoxin ○ ○ ○ ◉

Ibuprofen (Motrin) ○ ○ ○ ◉

Insulin or Diabetes ○ ○ ○ ◉

Sedatives or Tranquilizers ○ ○ ○ ◉

Sleeping Pills ○ ○ ○ ◉

Thyroid medications such as Synthriod, Levoxyl or Levothyroxine ○ ○ ○ ◉

Tylenol (Acetomeniphen) ○ ○ ○ ◉

Adverse reaction to any other medication or drug? If so, please explain

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_____

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_____

List the other medications you are currently taken and what condition you are taking them for. Include vitamin supplements herbs and other over-the-counter medications.

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_____

Pharmacy Name_____ **Phone**_____

Women: Are you pregnant? **Yes** ○ **No** ◉

Nursing? **Yes** ○ **No** ◉

Have you had any serious illnesses or surgeries? **Yes** ○ **No** ◉

_____

_____

Do you have any other health needs you should bring to our attention?

_____

_____

Tobacco Yes ○ No ◉
Packs per Day_____

Alcohol Yes ○ No ◉
Drinks per Day_____

Street Drugs Yes ○ No ◉
Times per Day_____

Caffeine Yes ○ No ◉
Cups per Day_____

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I., or my minor child, ever have a change in health.

Signature_____ **Date**_____