CROFTON FAMILY DENTISTRY
JOSEPH M. VARGAS, DDS

Medical History Form

Last Name: First Name: Birthdate:
Name of Medical Doctor: City/State:
Emergency Contact: Phone: Relationship:
List any/all medications and/or vitamins that you are currently taking:

Are you taking any of the following?

Y	N		Y	N		Y	N	
☐	☐	Acetaminophen	☐	☐	Cold Remedies	☐	☐	Thyroid Medicine
☐	☐	Antibiotics	☐	☐	Digitalis/Heart Medication	☐	☐	Tranquilizers
☐	☐	Antihistamines	☐	☐	Insulin/Diabetes Drugs	☐	☐	Have you ever taken Phen-Fen? Also known as Redux or Pondimin.
☐	☐	Aspirin	☐	☐	Nitroglycerin			
☐	☐	Blood Thinners	☐	☐	Recreational Drugs			
☐	☐	Blood Pressure Medication	☐	☐	Steroids/Cortisone			

Are you allergic to any of the following?

Y	N		Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Ibuprofen	☐	☐	Latex
☐	☐	Aspirin	☐	☐	Metals/Jewelry	☐	☐	Penicillin
☐	☐	Codeine	☐	☐	Iodine	☐	☐	Sulfa
						☐	☐	Tetracycline

Please list any other allergies you may have below:

Do you have/have you had any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Asthma	☐	☐	Drug Addiction or History of	☐	☐	Artifical Valves/Joint Replacement
☐	☐	Bleeding Problems	☐	☐	AIDS	☐	☐	Alcohol
☐	☐	Cancer/History Of	☐	☐	Acid Reflux	☐	☐	Gerd
☐	☐	Diabetes	☐	☐	Kidney Disease	☐	☐	Hepatitis A/B/C
☐	☐	Heart Murmur	☐	☐	Liver Disease	☐	☐	High Cholesterol
☐	☐	Congenital Heart Defect	☐	☐	Psychiatric Treatment	☐	☐	Radiation Treatment or History of
☐	☐	High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Rheumatic Fever
☐	☐	Chicken Pox	☐	☐	Stroke	☐	☐	Sexually Transmitted Disease
☐	☐	Epilepsy or Seizures	☐	☐	Ulcers	☐	☐	Tobacco Use
						☐	☐	Vertigo

Please list any other medical conditions you may have below:

For Women:	Are you taking birth control pills?	☐ Yes	☐ N	
	Are you pregnant?	☐ Yes	☐ N	Week #:
	Are you nursing?	☐ Yes	☐ N	

Tobacco use? If so, what kind and how much?
Unusual reaction to dental injections?
Reason for today's visit: Are you in pain?

New patients:
Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old?
Do you have BiteWing x-rays that are less than 1 year old?
Name of former Dentist: City/State:
Date of last cleaning and exam: