SPARKS DENTAL CLINIC **Medical History Form**

Updated every two years

☐ No Changes to Patient History
☐ New Patient History Completed

Patient's Name: **Date of Birth**

MEDICAL HISTORY: Please list Primary MEDICAL and/or BEHAVIORAL DIAGNOSIS		
1.)	2.)	3.)
4.)	5.)	6.)

Dental Issues Related to Primary Diagnoses: Completed by Sparks Dental Personnel

1. 4.
2. 5.
3. 6.

MEDICAL HISTORY

Please list **medications or supplements** the patient is taking: (Including vitamins, herbs, birth control pills, etc.)
☐ See attached list provided

MEDCATION/SUPPLEMENT	DOSE	HOW OFTEN GIVEN	REASON GIVEN

Has the patient been instructed to take ANTIBIOTICS before dental care?	Yes ☐	No ☑	Reason for Antibiotic Coverage	Sparks Dental Use Only: **Verification of Need for AB Coverage**

List any **allergic reactions** to medications or other substances:	☐ No Allergies
List any **hospital admissions**: Provide Approximate Date and reason for admission	☐ No Hospitalizations
List **surgeries** the patient has had: Provide Approximate Date and reason for surgery	☐ No Surgeries

Has the patient had **problems with any of the following systems or categories?**

	Yes		Yes		Yes
Genetic/Congenital Syndrome	☐	Leukemia	☐	Inflammatory diseases such as arthritis or rheumatism	☐
		Anemia	☐		
Cancer/ Tumors	☐	Prolong bleeding	☐	Artificial joint/ prosthesis	☐
Cancer treatment	☐	Diabetes	☐	Reflux problem (GERD)	☐
Congenital heart defect	☐	Epilepsy/seizure	☐	Liver disease/ Hepatitis	☐
Angina pectoris	☐	Spinal cord injury	☐	Kidney disease/infections	☐
Congestive heart failure	☐	Asthma	☐	Venereal disease	☐
Myocardial infarction (heart attack)	☐	Tubercuosis	☐	Alcohol/Tobacco use	☐
		Psychiatric/ Emotional	☐	Eye problems	☐
Pacemaker/ artificial heart valve implant	☐	Self-inflicted injuries	☐	Hearing loss	☐
		Muscular/skeletal problem	☐	Pregnancy (Currently)	☐
High blood pressure	☐	HIV positive/ AIDS	☐	COVID-19 Diagnosis	☐

Elaboration on YES answers above and additional information:

SIGNATURE _____ (_____) _____

Patient/Parent/ Guardian Print Name **Date**

_____ (_____) _____

Dentist Print Name **Date**