



NOELCK & MA FAMILY
— DENTISTRY —

MEDICAL HISTORY FORM

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____ Date Of Birth: _____ Gender: Male Female Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email Address: _____

Preferred Pharmacy: _____ Preferred Contact Method: Phone Text

EMERGENCY CONTACT

Full Name: _____ DOB: _____ Relationship: _____ Preferred Contact Method: Phone Text Email

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email: _____

MEDICAL INFORMATION

Primary Care Physician / Medical Doctor: _____ Phone Number: _____

Specialists Currently Seen: _____ Date of Last Physical Exam: _____

Have you been hospitalized or had surgery within the last 5 years? Yes No

If yes, explain: _____

Have you ever had any complications with anesthesia or sedation? Yes No

If yes, explain: _____

Are you currently under the care of a physician for any medical condition? Yes No

If yes, explain: _____

CURRENT MEDICATIONS

Please list all medications, supplements, vitamins, injections, and herbal remedies you are currently taking. **(OR PLEASE BRING LIST OF MEDS)**

Medication Name	Dosage	Reason Taken

GLP-1 / WEIGHT LOSS MEDICATIONS

Are you currently taking or have you recently taken any GLP-1 medications such as Ozempic, Wegovy, Mounjaro, Zepbound, Trulicity, Rybelsus, Saxenda, or similar medications?
 Yes No If yes:

Medication Name	Dosage	Reason Taken

ALLERGIES

Do you have any allergies or reactions to any of the following? If yes: Describe reaction(s): _____

- Penicillin
- Latex
- Sulfa Drugs
- Aspirin
- Codeine
- Local Anesthetics
- Metals
- Foods
- Seasonal Allergies
- Other: _____

TOBACCO, NICOTINE, ALCOHOL & SUBSTANCE USE

TOBACCO / NICOTINE USE

Do you currently use or have you previously used any of the following?

- Cigarettes
- Cigars
- Pipe Tobacco
- Smokeless Tobacco / Chew
- Hookah
- Vaping / E-Cigarettes
- Nicotine Pouches
- None

Current User? Yes No How much per day? _____ How many years? _____

Former User? Yes No How much per day? _____ How many years? _____

Date Quit (if applicable): _____

ALCOHOL USE

Do you consume alcohol? Yes No If yes, how often? _____

RECREATIONAL/ SUBSTANCE USE

Do you currently use recreational drugs or controlled substances? Yes No If yes, please specify: _____

WOMEN ONLY

Are you currently:

- Pregnant
- Trying to become pregnant
- Nursing / Breastfeeding
- Taking birth control pills

Taking hormone replacement therapy or hormone medications

If pregnant, what is your due date? _____

MENTAL HEALTH & GENERAL HEALTH

Over the past two weeks, have you felt connected to the world around you and emotionally well? Yes No Do you currently experience or have a history of:

- Anxiety
- Depression
- Panic Attacks

- Eating Disorder
- Sleep Disorders
- Other Mental Health Condition: _____

MEDICAL CONDITIONS

Please check any condition you currently have or have had in the past.

HEART & CIRCULATION

- High Blood Pressure
- Low Blood Pressure
- Heart Attack
- Heart Murmur
- Irregular Heartbeat

- Angina / Chest Pain
- Stroke
- Congestive Heart Failure

- Pacemaker
- Artificial Heart Valve
- Rheumatic Fever
- High Cholesterolo

BLOOD DISORDERS

- Anemia
- Excessive Bleeding
- Blood Clotting Disorder

- Blood Transfusion History
- Hemophilia

BLOOD THINNERS

Are you currently taking blood thinners? Yes No If yes, please check all that apply:

- Warfarin / Coumadin
- Eliquis
- Xarelto

- Pradaxa
- Plavix

- Aspirin Therapy
- Other: _____

RESPIRATORY

- Asthma
- COPD / Emphysema
- Chronic Cough

- Tuberculosis
- Sleep Apnea
- Shortness of Breath

ENDOCRINE / HORMONAL

- Diabetes Type 1
- Diabetes Type 2

NEUROLOGICAL

- Seizures / Epilepsy
- Migraines
- Fainting / Dizziness
- Neurological Disorder

DIGESTIVE / GASTROINTESTINAL

- Acid Reflux / GERD
- Ulcers
- Liver Disease
- Hepatitis
- Chronic Nausea / Vomiting

- Thyroid Disease

KIDNEY / IMMUNE

- Kidney Disease
- Dialysis
- Autoimmune Disorder
- HIV/AIDS
- Cancer / Chemotherapy
- Radiation Treatment

BONE & JOINT

- Arthritis
- Artificial Joint Replacement
- Chronic Pain Disorder

- Osteoporosis
- Hormone Disorder

INFECTIOUS DISEASES

- MRSA
- Tuberculosis
- COVID-19 complications

OTHER CONDITIONS

- Sinus Problems
- Glaucoma
- Frequent Headaches
- Eating Disorder
- Any condition not listed above

Please explain any condition checked above: _____

ACKNOWLEDGEMENT

I certify that the above information is accurate to the best of my knowledge. I understand that providing incorrect information may affect my treatment or insurance processing.

Patient/Responsible Party Signature: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: Medical Alert Premedication Allergies Anesthesia

Reviewed By: _____ Date Reviewed: _____