# Stummer Dental and Sleep Medicine Center

***MEDICAL HISTORY***
***FOR***

_____

**Date of Birth** _____

**Please answer the following health questions so that we may be aware of any health problems or medications that you are taking. These could have an important Interrelationship with the dental care that you receive in the future.**

**What is the main reason or goal for your visit today?**_____
**Who is your Primary Care Physician?**_____
**Please list any conditions you are currently being treated for and the treating Doctor.**
**Condition**_____ **Condition**_____
**Doctor**_____ **Doctor**_____

**YES NO Have you ever had a serious head or neck injury?**
**Please describe**_____

**YES NO Do you use any type of tobacco, e-cigarettes or hookah pipes?**

**YES NO Do you have a history of drug or alcohol abuse?**

**YES NO Have you ever taken any of the following: Phen-Fen, Redux, Fosamax, Boniva, Aconel or other medications containing bisphosphonates?**
**Please list**_____
**Women:**
**YES NO Are you Pregnant or trying to get pregnant?**
**YES NO Taking Oral Contraceptives?**
**YES NO Nursing?**

**Please list all medications, supplements and vitamins with dosages that you are currently taking.**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**Are you allergic to any of the following: (Please circle.)**
**Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal**

**Latex Tree Nuts Peanuts Sulfa drugs**

**Please list any other drugs you are allergic to:**_____

**Authorization for disclosure of Medical Records**

**I authorize the disclosure of any of my medical records to the following people:**

| | |
|---|---|
| **Name** | Relationship |
| **Name** | Relationship |
| **Name** | Relationship |