Nexus Dental

1168 W Main St, Suite #E, Lewisville, TX-75067

Medical History

Patient First Name: Last Name: Date of Birth:

HEALTH HISTORY

Are you currently under the care of a physician? ○Yes ○No

Physician Name: Physician Phone Number:

Have you ever been hospitalized or had a major operation? ○Yes ○No

If yes, please explain:

MEDICAL HISTORY

Do you have allergies to any of the following?

Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Acrylic
☐	☐	Codeine/Narcotics	☐	☐	Latex
☐	☐	Local Anesthetics	☐	☐	Metal/Nickel
☐	☐	Penicillin/Other Antibiotic	☐	☐	Sulfa Drugs
☐	☐	Other:			

Do you have, or have you had any of the following medical conditions? (If yes, please provide date and explanation.)

Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Arthritis
☐	☐	Artificial Joints	☐	☐	Asthma
☐	☐	Anxiety/Nervousness	☐	☐	Blood Disease
☐	☐	Cancer	☐	☐	Coronary Artery Blockage (Bypass/Stent)
☐	☐	Diabetes	☐	☐	Dizziness
☐	☐	Epilepsy /Seizures	☐	☐	Excessive Bleeding
☐	☐	Fainting Glaucoma	☐	☐	Head/Neck Injuries
☐	☐	Heart Disease	☐	☐	Hepatitis
☐	☐	High Blood Pressure	☐	☐	HIV
☐	☐	Kidney Disease	☐	☐	Liver Disease
☐	☐	Mental Disorders	☐	☐	Nervous Disorders
☐	☐	Osteoporosis	☐	☐	Organ Transplant
☐	☐	Pacemaker	☐	☐	Radiation Treatment
☐	☐	Respiratory Problems/ COPD	☐	☐	Rheumatic Fever
☐	☐	Rheumatism	☐	☐	Sinus Problems
☐	☐	Stomach Problems	☐	☐	Stroke
☐	☐	Stomach Ulcers	☐	☐	Tuberculosis
☐	☐	Venereal Disease	☐	☐	Other

Female only: Are you currently

Yes	No		Yes	No		Yes	No	
☐	☐	Pregnant	☐	☐	Nursing	☐	☐	Taking Birth Control Pills

Are you currently taking any of the prescription or over the counter medications? ○**Yes** ○**No**

If yes, please list them:

Have you ever had any joint replacement? ○**Yes** ○**No**

If yes, provide date and explanation:

Do you take, or have you taken, PhenFen or Redux? ○**Yes** ○**No**

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○**Yes** ○**No**

If yes, please explain:

Do you use tobacco in any form? ○**Yes** ○**No**

Do you use controlled substances? ○**Yes** ○**No**

If yes, please explain:

Patient/Guardian Signature: _____ **Date:** ____/____/_____

Patient/Guardian Signature: _____ **Updated Form:** ____/____/_____