Ivry Dental - Alpharetta
Comprehensive and Cosmetic Care
6195 Windward Pkwy Suite 108
Alpharetta, GA 30005

Medical History Form

Your health is important to us. The information below helps us provide safe, personalized dental care. Please answer all questions accurately and completely.

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1. Primary Care Information

Primary Care Physician: ______________________________________

Physician Phone Number: _____________________________________

Date of Last Physical Exam (if known): __________________________

Are you currently under medical care? ☐ No ☐ Yes

If Yes — please explain: ____

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2. Medications

Are you currently taking any medications, vitamins, injections, or herbal supplements?

☐ No ☐ Yes

If yes— please list (include dosages):

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3. Allergies

Are you allergic to any of the following? (Check all that apply)

☐ Penicillin ☐ Amoxicillin ☐ Latex ☐ Aspirin ☐ Codeine ☐ Local anesthetic

☐ Sulfa drugs ☐ No known allergies

☐ Other medication — please specify:

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____

Describe reaction if applicable:

____

____

4. Medical Conditions

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

Heart & Circulatory

☐ High blood pressure ☐ Low blood pressure ☐ Heart disease
☐ Heart attack ☐ Heart murmur ☐ Irregular heartbeat
☐ Pacemaker ☐ Artificial heart valve ☐ Stroke

Respiratory

☐ Asthma ☐ COPD ☐ Sleep apnea

Endocrine / Metabolic

☐ Diabetes (Type I / Type II) ☐ Thyroid disorder ☐ Autoimmune disorder

Bleeding / Immune

☐ Bleeding disorder ☐ Anemia ☐ Immunocompromised
☐ HIV/AIDS

Bone / Joint

☐ Osteoporosis ☐ Artificial joint (hip/knee/etc.)

Neurological

☐ Seizures ☐ Frequent headaches/migraines

Gastrointestinal

☐ GERD ☐ Crohn's disease ☐ Ulcerative colitis

Cancer

☐ History of cancer ☐ Radiation therapy ☐ Chemotherapy

Other

☐ Anxiety ☐ Depression ☐ Kidney disease
☐ Liver disease ☐ Hepatitis (A, B, C) ☐ None of the above

If yes to any condition, please explain:

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5. Women's Health

Are you currently pregnant or nursing?

☐ No
☐ Yes
☐ Possibly

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6. Lifestyle

Do you use tobacco?

☐ No

☐ Yes — ☐ Smoking ☐ Vaping ☐ Other

Do you use marijuana?

☐ No ☐ Yes

Do you consume alcohol?

☐ No ☐ Occasionally ☐ Regularly

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7. Antibiotic Premedication

Have you ever been told you require antibiotics before dental treatment?

☐ No ☐ Yes ☐ Unsure

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8. Changes in Health

Have you experienced any recent changes in your health?

☐ No

☐ Yes — please explain: ____

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9. Acknowledgment

I certify that the information provided above is accurate and complete to the best of my knowledge. I understand that it is my responsibility to inform Ivry Dental of any changes in my medical condition or medications.

Patient Signature: ____

Printed Name: ____

Date: __________________