MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____

Are you under the care of a physician? Yes ☐ No ☐

If Yes, for what reason(s)?_____

Physician Name & Office Name:_____ Last Examination Date:_____

Do you have, or have ever had:

Heart Disease..... Yes ☐ No ☐

Open heart surgery..... Yes ☐ No ☐

Rheumatic fever..... Yes ☐ No ☐

Artificial heart valve/stent/graft..... Yes ☐ No ☐

Stroke..... Yes ☐ No ☐

Stomach/intestinal trouble..... Yes ☐ No ☐

Tuberculosis or lung disease..... Yes ☐ No ☐

Sinus trouble..... Yes ☐ No ☐

Epilepsy / seizures..... Yes ☐ No ☐

Anemia ..... Yes ☐ No ☐

Excessive or prolonged bleeding ..... Yes ☐ No ☐

Leukemia ..... Yes ☐ No ☐

Chemotherapy/radiation..... Yes ☐ No ☐

Hepatitis(Type)_____..... Yes ☐ No ☐

Cortico-Steroid treatment..... Yes ☐ No ☐

Osteoporosis - treatment w/Bisphosphonates..... Yes ☐ No ☐

HIV positive/AIDS..... Yes ☐ No ☐

Sexually Transmitted disease ..... Yes ☐ No ☐

Depression..... Yes ☐ No ☐

Glaucoma..... Yes ☐ No ☐

Hearing impaired ..... Yes ☐ No ☐

Heart murmur..... Yes ☐ No ☐

Heart pacemaker..... Yes ☐ No ☐

Congenital heart defects..... Yes ☐ No ☐

Abnormal High/Low blood pressure..... Yes ☐ No ☐

Ulcers/ GERD..... Yes ☐ No ☐

Kidney trouble/Dialysis ..... Yes ☐ No ☐

Asthma..... Yes ☐ No ☐

Sleep Apnea..... Yes ☐ No ☐

Fainting spells..... Yes ☐ No ☐

Diabetes ..... Yes ☐ No ☐

Thyroid problem..... Yes ☐ No ☐

Cancer..... Yes ☐ No ☐

Jaundice or Liver Disease..... Yes ☐ No ☐

Arthritis ..... Yes ☐ No ☐

Joint Replacement/Synthetic Implant.....Yes ☐ No ☐

Circulatory Problems.....Yes ☐ No ☐

Oral herpetic lesions..... Yes ☐ No ☐

Psychiatric care..... Yes ☐ No ☐

Chemical dependency..... Yes ☐ No ☐

Eye, Ear, Nose, Throat trouble.....Yes ☐ No ☐

Excessive Fatigue ..... Yes ☐ No ☐

Severe headaches/migraines……..Yes ☐ No ☐

Morning headaches……..Yes ☐ No ☐

Do you snore?..... Yes ☐ No ☐

Do you smoke?..... Yes ☐ No ☐

(Women Only)

Oral contraceptives ..... Yes ☐ No ☐

Are you pregnant?..... Yes ☐ No ☐

If yes, when is your due date? _____

Have you had any other serious illness, hospitalization and/or accident? Yes ☐ No ☐

If yes, please explain: _____

_____

Do you take pre-medication for anything? Yes ☐ No ☐ If Yes, for what? _____

Are you presently taking any medications/drugs/pills/herbals/supplements? Yes ☐ No ☐

If Yes, please list them: _____

_____

Are you allergic/sensitive to:

☐ None ☐ Penicilin ☐ Local Anesthetic ☐ Metals (nickel, gold, silver)

☐ Sulfra Drug ☐ Eythromycin ☐ Tetracycline ☐ Fluoride

☐ Latex ☐ Pine Nuts ☐ Dyes

☐ Aspirin, Ibuprofen, Cetaminophen, Codeine ☐ Other _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is the patient's responsibility to inform the dental office of any changes in medical status.

Patient Signature: _____ Date: _____