

MEDICAL HISTORY

NAME _____ BIRTHDATE _____
 Physician's Name _____ Phone _____
 Address _____

Are you currently under the care of a physician? Yes No
 If Yes, for what reason? _____

Please list all of the medications that you are taking in the box to the right →→→→→→
 Have you ever taken prescription drugs for weight loss (i.e. PhenFen or Redux)? Yes No
 Have you ever taken medications for Osteoporosis (i.e. Fosomax, Aredia, Boniva)? Yes No
 Are you, or have you ever taken any "Blood Thinners" (i.e. Coumadin, Plavix) Yes No
 Do you currently, or have you had to, take antibiotics before dental treatment? Yes No

List **ALL** medications including prescription, over-the-counter, vitamins and supplements:

ALLERGIES

Are you allergic (or have an adverse reaction) to: *Check all that apply or check none*

Penicillin Codeine Local Anesthetic None
 Aspirin Other Antibiotics Other Medications or Substances

Are you sensitive or allergic to latex? (Have you experienced itching, rash or wheezing after using latex gloves or handling a balloon) Yes No
 Have you had any unusual or unexplained reactions during a surgical procedure? Yes No Explain: _____
 Hearing impaired? Yes No

Do you have, or have you ever had any of the following. (Yes or No)

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (check one)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Implants	<input type="checkbox"/>	<input type="checkbox"/>	Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/>	<input type="checkbox"/>
Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Ailments	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone medicine	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive/AIDS/ARC	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disorders	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	GERD (gastric reflux)	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Removal of spleen	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia/Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>			

DR COMMENTS:

Premedication Required _____

Do you currently smoke or use the following tobacco products?
 Cigarette Packs/Day? _____ Cigars Pipe Chew None

WOMEN: Are you pregnant? Yes No
 Do you take any birth control medications? Yes No
 If yes, please note: _____

Have you used tobacco products in the past? Yes No How long ago? _____

Have you had any other serious illness, hospitalization or accident?
 If yes, please explain _____

Would you like to speak to the doctor privately about any problem? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify this doctor of my changes in my health or medication.

Patient's Signature _____ Date _____
 (PARENT/GUARDIAN OF A MINOR)