MEDICAL HISTORY

Patient name_____Name/location of medical doctor_____

Have you ever been told you need to take an antibiotic before dental visits?_____

Are you under physician's care now? ___Y___N If yes, please explain:_____

Have you been hospitalized or had major surgery in the last 10 years? ___Y___ N

If yes, please explain:_____

Have you ever had a serious head or neck injury? ___Y___N If yes, please explain:_____

Are you taking medications, pills, or drugs? ___Y___N If yes, please explain:_____

Do you take blood thinners, ex. Coumadin, Warfarin, Plavix, Effient? ___Y___N

Do you, or have you taken, bisphophonates, ex. Boniva or Actonel? ___Y___N

Do you, or have you taken, Phen-Fen or Redux? ___Y___N

Are you on a special diet?___Y___N Do you use tobacco? ___Y___N Controlled substances?___Y___N

Women, are you:

Pregnant/Trying to get pregnant?___Y___N Taking oral contraceptives___Y___N Nursing___Y___N

Are you allergic to any of the following? ___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal

___Latex ___Local Anesthetics ___Other (Please list) _____

Do you have, or have had, any of the following?

AIDS/HIV Positive	___Y___N	Cortisone Medicine	___Y___N	Hemophilia	___Y___N
Alzheimer's Disease	___Y___N	Diabetes	___Y___N	Hepatitis A	___Y___N
Anaphylaxis	___Y___N	Drug Addiction	___Y___N	Hepatitis B or C	___Y___N
Anemia	___Y___N	Easily Winded	___Y___N	Herpes	___Y___N
Angina	___Y___N	Emphysema	___Y___N	High Blood Pressure	___Y___N
Arthritis/Gout	___Y___N	Epilepsy or Seizures	___Y___N	Hives or Rash	___Y___N
Artificial Heart Valve	___Y___N	Excessive Bleeding	___Y___N	Hypoglycemia	___Y___N
Artificial Joint	___Y___N	Excessive Thirst	___Y___N	Irregular Heartbeat	___Y___N
Asthma	___Y___N	Fainting Spells/Dizzy	___Y___N	Kidney Problems	___Y___N
Blood Disease	___Y___N	Frequent Cough	___Y___N	Leukemia	___Y___N
Blood Transfusion	___Y___N	Frequent Diarrhea	___Y___N	Liver Disease	___Y___N
Breathing Problem	___Y___N	Frequent Headaches	___Y___N	Low Blood Pressure	___Y___N
Bruise Easily	___Y___N	Genital Herpes	___Y___N	Lung Disease	___Y___N
Chemotherapy	___Y___N	Hay Fever	___Y___N	Pain in Jaw Joints	___Y___N
Chest Pains	___Y___N	Heart Attack/Failure	___Y___N	Parathyroid Disease	___Y___N
Cold Sores	___Y___N	Heart Murmur	___Y___N	Psychiatric Care	___Y___N
Cong. Heart Disorder	___Y___N	Heart Pace Maker	___Y___N	Radiation Treatments	___Y___N
Convulsions	___Y___N	Heart Trouble/Disease	___Y___N	Recent Weight Loss	___Y___N

Please turn over

Renal Dialysis	___Y___N	Sinus Trouble	___Y___N	Tonsillitis	___Y___N
Rheumatic Fever	___Y___N	Spina Bifida	___Y___N	Tuberculosis	___Y___N
Rheumatism	___Y___N	Stomach/Intestinal	___Y___N	Tumor/Growth	___Y___N
Scarlet Fever	___Y___N	Stroke	___Y___N	Ulcers	___Y___N
Shingles	___Y___N	Swelling of Limbs	___Y___N	Venereal Disease	___Y___N
Sickle Cell Disease	___Y___N	Thyroid Disease	___Y___N	Yellow Jaundice	___Y___N

Have you ever had any serious illness not listed above? If yes, please explain:

_____

Comments:

_____

_____

_____

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 my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, Guardian**:**_____

Date:_____