

**MEDICAL HISTORY**

Patient Name:

Birth Date:

Date Created:

Do you have a current physician? If so, please write their name(s):  Yes  No If yes

Do you know the date of your last dental exam?  Yes  No If yes

Have you been hospitalized or had a major operation within the past 5 years?  Yes  No If yes

Have you ever had a serious head or neck injury?  Yes  No If yes

Are you taking any medications, pills, or drugs?  Yes  No If yes

Do you smoke or use tobacco?  Yes  No If yes

Have you ever been told to premedicate with antibiotics prior to dental treatment?  Yes  No If yes

Have you ever been prescribed Aspirin, Coumadin, Plavix or any other blood-thinning medicine?  Yes  No If yes

Do you have a primary dental concern at this time?  Yes  No If yes

Does dental treatment make you nervous?  Yes  No If yes

Have you ever had any serious trouble associated with previous dentistry?  Yes  No If yes

Are you happy with the appearance of your teeth?  Yes  No

For women: Are you...  
 Pregnant/Trying to get pregnant?  Nursing?

Have you ever taken an osteoporosis medication such as Fosamax, Boniva or other?  Yes  No If yes

Are you allergic to any of the following?  
 Penicillin  Codeine  Metal  Latex  
 Local Anesthetics  Sulpha

Other allergies:  Yes  No If yes

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

Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Cardiac Transplant <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No
Cancer-Malignancy <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No
Joint Infection <input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Heart Attack <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No
Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Infective Endocarditis <input type="radio"/> Yes <input type="radio"/> No	Angina <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No
Diabetes <input type="radio"/> Yes <input type="radio"/> No	Abnormal Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Fainting/Dizziness <input type="radio"/> Yes <input type="radio"/> No
Rheumatoid Arthritis <input type="radio"/> Yes <input type="radio"/> No	TMJ Problems <input type="radio"/> Yes <input type="radio"/> No	Congestive Heart Failure <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No
Drug or Radiation-Induced Immunosuppress <input type="radio"/> Yes <input type="radio"/> No	Dry Mouth <input type="radio"/> Yes <input type="radio"/> No	Emphysema/COPD <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding or Bruising <input type="radio"/> Yes <input type="radio"/> No
Systemic Lupus <input type="radio"/> Yes <input type="radio"/> No	Periodontal/Gum Disease <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cold Sores <input type="radio"/> Yes <input type="radio"/> No	Hepatitis <input type="radio"/> Yes <input type="radio"/> No	Pacemaker <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?  Yes  No If yes

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 or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_