MEDICAL HISTORY

Name _____ Date _____

Answer the following questions by circling either Yes or No, whichever applies. Your answers are for our records and will be considered confidential. During your treatment visit(s) you may be asked additional questions about your responses and your health.

1. Do you consider yourself to be in good health? . . . . . Yes No

2. Has there been any change in your general health within the past year? . . . . . Yes No

3. Personal physician _____ Date of last medical doctor visit _____

4. Are you now under the care of a physician? Yes No If Yes, nature of treatment _____

5. Have you had any serious illness, operation, or been hospitalized in the past 5 years? . . . . . Yes No

   If Yes, what was the nature of the illness or problem? _____

6. Are you taking any medicine(s) including non-prescription medicine at this time? . . . . . Yes No

   If Yes, what medicine(s) are you taking? _____

   _____

7. Have you ever had an allergic reaction to any drugs or medications? . . . . . Yes No

   If Yes, what medicine(s) or drug(s)? _____

8. Do you have or have you had any of the following diseases or problems?

Damaged Heart Valves	Yes	No	Latex Allergy	Yes	No
Heart Murmur	Yes	No	Inborn Heart Defect(s)	Yes	No
Rheumatic Heart Disease	Yes	No	Cardiac Pacemaker	Yes	No
Bacterial Endocarditis	Yes	No	Allergies	Yes	No
Mitral Valve Prolapse	Yes	No	Sinus Trouble	Yes	No
Heart Trouble	Yes	No	Asthma or Hay Fever	Yes	No
Heart Attack	Yes	No	Fainting Spells or Seizures	Yes	No
Angina	Yes	No	Persistent Diarrhea	Yes	No
Coronary Insufficiency	Yes	No	Recent Weight Loss	Yes	No
High Blood Pressure	Yes	No	Diabetes	Yes	No
Arteriosclerosis	Yes	No	Hepatitis, Jaundice, or Liver Disease	Yes	No
Stroke	Yes	No	AIDS or HIV Infection	Yes	No
Chest Pain Upon Exertion	Yes	No	Thyroid Problems	Yes	No
Shortness of Breath	Yes	No	Respiratory Problems	Yes	No
Ankle Swelling	Yes	No	Persistent Cough That Produces Bleeding	Yes	No
Swollen Joints, Arthritis	Yes	No	Low Blood Pressure	Yes	No
Stomach Ulcer or Hyperacidity	Yes	No	Sexually Transmitted Disease	Yes	No
Persistent Swollen Glands in Neck	Yes	No	Epilepsy	Yes	No

Kidney Trouble . . . . . Yes No

Tuberculosis. . . . . .Yes No

Immune System Problems. . . . . Yes No

Mental Health Problems. . . . . .Yes No

Cancer. . . . . .Yes No

Bleeding of Gums. . . . . .Yes No

9. Have you traveled outside the U.S. in the past 6 months? Where? _____ Yes No

10. Do you take herbs and if so, which ones? . . . . . Yes No

11. Do you take aspirin daily? . . . . . .Yes No

12. Have you ever had abnormal bleeding? . . . . . Yes No

13. Have you ever had a blood transfusion? . . . . . .Yes No

14. Do you have any blood disorder such as anemia? . . . . . Yes No

15. Have you ever had any treatment for a tumor or growth? . . . . . Yes No

16. Are you allergic to or have you ever had a reaction to:
    a. Local Anesthetics . . . . . .Yes No
    b. Penicillin or other antibiotics . . . . . Yes No
    c. Sulfa drugs. . . . . .Yes No
    d. Barbiturates, sedatives, or sleeping pills . . . . . Yes No
    e. Aspirin . . . . . .Yes No
    f. Iodine . . . . . Yes No
    g. Codeine or other narcotics . . . . . Yes No
    h. Latex . . . . . Yes No

17. Have you consumed more than 1 ounce of alcohol within the last 24 hours? . . . . . Yes No

18. Have you ever had any serious trouble associated with any previous dental treatment? . . . . . Yes No

19. Do you have any disease, condition, or problem not listed above that I should know about? . . . . . Yes No

20. Do you wear contact lenses? . . . . . Yes No

21. Are you wearing removable dental appliances? . . . . . .Yes No

22. Are you taking **Bisphosphonates** for osteoporosis or cancer?. . . . . .Yes No

WOMEN

23. Are you pregnant? . . . . . .Yes No

24. Do you have any problems associated with your menstrual periods? . . . . . Yes No

25. Are you nursing? . . . . . .Yes No

26. Are you taking birth control pills? . . . . . Yes No

What is your main dental problem at this time?_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the questions above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

signature of patient

signature and relationship of any other person completing this form

Thank you for filling out this form completely.
It will help us to better serve your dental needs.
If you have any questions at any time,
Please do not hesitate to ask.