Medical History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you or have you ever been treated for:

	Yes	No		Yes	No		Yes	No
Any Heart Problems	☐	☐	Do you Smoke?	☐	☐	Allergic Reactions:		
Congenital Heart Disease *	☐	☐	Lung / Breathing problems	☐	☐	Penicillin	☐	☐
Mitral Valve Prolapse *	☐	☐	Asthma	☐	☐	Erythromycin	☐	☐
Heart Valve Defect*	☐	☐	Bronchitis	☐	☐	Sulfa	☐	☐
Epsteins Disease *	☐	☐	Emphysema	☐	☐	Codeine	☐	☐
Heart Valve Replacement *	☐	☐	Tuberculosis	☐	☐	Aspirin	☐	☐
Rheumatic Fever *	☐	☐	Sinus Trouble	☐	☐	Latex	☐	☐
Artificial Joint (Hip / Knee) *	☐	☐	Difficulty Healing	☐	☐	Local Anesthetic	☐	☐
Angina	☐	☐	Diabetes	☐	☐	Other Medication (Please List)		
Stroke	☐	☐	Thyroid Problems	☐	☐	______________________	☐	☐
Heart Attack	☐	☐	Adrenal / Pituitary Disorders	☐	☐	______________________	☐	☐
Bypass	☐	☐	Liver Disorder / Dysfunction	☐	☐	______________________	☐	☐
Pacemaker	☐	☐	Hepatitis / Jaundice	☐	☐	Cancer / Tumor	☐	☐
High Blood Pressure	☐	☐	Kidney Disorder / Dysfunction	☐	☐	Other Growths	☐	☐
Low Blood Pressure	☐	☐	Renal Dialysis	☐	☐	Chemotherapy / Radiation Therapy	☐	☐
Any Bleeding Disorders	☐	☐	Stomach Trouble / Ulcers	☐	☐	Sexually Transmitted Diseases	☐	☐
Anemia	☐	☐	Nervous or Mental Disorder	☐	☐	HIV / AIDS	☐	☐
Hemophilia	☐	☐	Epilepsy or Seizures	☐	☐			
Sickle Cell Trait	☐	☐	Alcoholism	☐	☐			
Blood Transfusions	☐	☐	Drug Abuse	☐	☐			
Are you Pregnant?	☐	☐	Fainting Spells	☐	☐			

Have you ever had a major operation or been hospitalized? ☐ Yes ☐ No Explain: ____

____

Have you ever had a serious injury to your head or neck? ☐ Yes ☐ No Explain: ____

____

* Do you need to take antibiotic premedication prior to dental appointments? ☐ Yes ☐ No ☐ Don't know
Name of antibiotic: ____

Do you have any current health problems not noted above? ☐ Yes ☐ No What? ____

Are you currently being treated by a physician? ☐ Yes ☐ No Why? ____

Physician's name, address, and phone: ____

Are you presently taking any medications? ☐ Yes ☐ No Please list:

Name:	For:	Name:	For:
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

To the best of knowledge, the foregoing questions have been accurately answered.

Signature ____ Date ____________________

Print name ______________________________ If other than patient, indicate relationship____________________