

Medical History

Patient's Name _____ Date of Birth _____

Physician's Name _____ Address _____

Physician's Phone _____ Are you under a physician's care now? _____ Since when? _____

Why are you under his care? _____ Last complete medical exam _____

CIRCLE the appropriate answer, if you don't know the correct answer, please write DON'T KNOW on the line after the question.

Please explain YES answers in comments section.

			COMMENTS
YES	NO	1. Are you taking any medications or substances. Please list	
YES	NO	2. Do you routinely take health related substances? Please list	
YES	NO	3. Are you allergic to any medications? Please list	
YES	NO	4. Do you have any other allergies? Please list	
YES	NO	5. Do you have any problems with penicillin, antibiotics	
YES	NO	anesthetics or other medications? Please list	
YES	NO	6. Are you sensitive to any metals or latex?	
YES	NO	7. Women: Are you pregnant or suspect you may be?	
YES	NO	8. Women: Do you use any birth control medications?	
YES	NO	9. Women: Do you have breast implants?	
YES	NO	10. Men: Have you or are you currently taking Viagra/Cialis/Levitra?	
YES	NO	11. Have you ever been told you might have heart disease?	
YES	NO	12. Do you use Nitro Tablets? DR WANTS AT EVERY VISIT	
YES	NO	13. Do you have a pacemaker or artificial heart valve?	
YES	NO	14. Are you taking a blood thinner?	
YES	NO	15. Have you ever had rheumatic fever or scarlet fever?	
YES	NO	16. Are you aware of any heart murmurs or mitral valve prolapse?	
YES	NO	17. Have you ever had a stroke or mini strokes (TIA)?	
YES	NO	18. Do you experience dizzy episodes?	
YES	NO	19. Do you have high or low blood pressure?	
YES	NO	20. Have you had an organ transplant of any kind? Please explain	
YES	NO	21. Have you had any artificial joints or pins in bones?	
YES	NO	22. Has your physician recommended antibiotics prior to dental visits?	
YES	NO	23. Do you have a history of migraines?	
YES	NO	24. Do you have thyroid disease?	
YES	NO	25. Do you experience pain in your jaws (TMJ)?	
YES	NO	26. Do you have inflammatory disease (like arthritis, rheumatism, lupus)?	
YES	NO	27. Do you have a blood disorder: anemia, leukemia, etc?	
YES	NO	28. Have you ever bled excessively after being cut or injured?	
YES	NO	29. Do you have any stomach problems, (ulcers, Crohn's etc.)	
YES	NO	30. Do you have any kidney problems?	
YES	NO	31. Do you have any liver problems?	
YES	NO	32. Are you diabetic or prediabetic? What medications are you on?	
YES	NO	33. Do you have emphysema? Do you use supplemental oxygen?	
YES	NO	34. Do you have asthma?	
YES	NO	35. Do you have an inhaler? BRING INHALER AT EVERY VISIT	
YES	NO	36. Do you have epilepsy or seizure disorders?	
YES	NO	37. Have you tested positive for TB?	
YES	NO	38. Do you have or have you had venereal disease?	
YES	NO	39. Have you tested positive for HIV or AIDS?	
YES	NO	40. Have you had or do you test positive for hepatitis?	
YES	NO	41. Do you smoke, chew, use snuff or any other form of tobacco?	
YES	NO	42. Do you consume alcoholic beverages?	
YES	NO	43. Do you habitually use controlled substances?	
YES	NO	44. Have you had psychiatric treatment?	
YES	NO	45. Have you taken Fosamax or Actonel? For how long?	
YES	NO	46. Have you ever had radiation or chemo treatment for cancer?	
YES	NO	47. Have you had a serious illness or major surgery? Please explain	
YES	NO	48. Do you have any disease condition or problem not listed here?	

I certify that the above information is complete and accurate.

Patient's/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____