Name _____ Date of birth _____ Date _____

Medical Information

For the following questions, please (X) whichever applies, your answers are for our records only & will be kept confidential.

Date of last physical examination: _____

Physician #1: _____
Name Phone

_____
Address City/State/Zip

Physician #2: _____
Name Phone

_____
Address City/State/Zip

Yes No

O O Has there been any change in your general health within the past year?

What is/are the condition(s) being treated? _____

_____

_____

O O Have you had any serious illness, operation, or been hospitalized in the past 5 years? _____

O O Are you taking or have you recently taken any prescription medications, over the counter medications or herbal supplements?

Please list all medications and supplements

Drug	Dosage	For what condition

Are you allergic or have you had a reaction to any of the following? If yes, please specify type of reaction.

O O Local anesthetics _____
O O Aspirin / Ibuprofen _____
O O Penicillin or other antibiotics _____
O O Barbiturates, sedatives or sleeping pills _____
O O Sulfa Drugs _____
O O Codeine or other narcotics _____
O O Latex _____
O O Other (specify) _____
O O Metals (specify) _____

Antibiotic Prophylaxis

O O Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
For what condition? _____

O O Have you had an orthopedic total joint (hip, knee, elbow) replacement? If yes, date of surgery _____
Location of joint replaced _____

O O AIDS or HIV infection
O O Arthritis
O O Blood thinning medication
O O Abnormal bleeding / Anemia / Hemophilia
O O Cancer/Chemotherapy/Radiation Treatment
If yes, Type _____
When Treated _____
Current Status _____

O O Radiation to head or neck Date _____
O O Immunosupression (Disease, drug, or radiation induced)
O O Recurrent infections
If yes, specify type of infection: _____
O O Chronic pain
O O Diabetes Type I _____ Type II _____

Yes No

O O Cardiovascular disease If yes, specify below:
- **O** Heart Murmur
- **O** High blood pressure
- **O** Artificial Heart Valves
- **O** Congenital heart defects
- **O** Congestive heart failure
- **O** Coronary artery disease
- **O** Damaged heart valves
- **O** Heart Attack
- **O** Arrhythmia
- **O** Angina / Chest Pain upon exertion
- **O** Angioplasty
- **O** Low blood pressure
- **O** Mitral valve prolapse
- **O** Pacemaker
- **O** Rheumatic heart disease/Rheumatic fever
- **O** Stent
- **O** By-pass surgery

O O Stroke Date _____
O O Eating disorder If yes, specify: _____
O O Epilepsy, seizures or fainting Date of last episode _____
O O Frequent headaches/migraines
O O Gastrointestinal disease / Reflux / Heartburn
O O Hepatitis, jaundice, cirrhosis or liver disease _____
O O Kidney problems _____
O O Mental health disorders _____
O O Neurological disorders. _____
O O Respiratory problems. If yes, please specify
- **O** COPD (Congestive Obstructive Pulmonary Disease)
- **O** Emphysema **O** Bronchitis **O** Asthma
- **O** Other _____

O O Sexually transmitted disease
O O Sinus trouble
O O Thyroid problems
O O Tuberculosis. Date _____ Treatment _____
Current status _____
O O Persistent cough greater than 3 week duration
O O Do you drink alcoholic beverages?
If yes, how much weekly? _____
O O Do you have a history of drug or alcohol dependency?
If yes, please describe and give current status.
_____
O O Do you use tobacco (smoking, snuff, chew)?
If yes, number of years of use _____
Amount used daily? _____
O O Do you have a history of tobacco use?
If yes, when did you quit? _____

WOMEN ONLY

O O *Are you or could you be pregnant?*
O O *Nursing?*
O O *Taking oral contraceptives?*

Do you have any disease, condition, or problem not listed above that you think I should know about?
Please explain: _____

_____

I hereby grant permission for the administration of such medications and the performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

The information on this Medical History form are correct to the best of my knowledge. I will notify this office if there are any changes in my Medical or Dental History.

_____ / _____

Patient/Legal Guardian Signature **Date**