MEDICAL HISTORY

Patient Name_____ Preferred Name _____ Age _____

Name of Physician _____

Most recent physical examination _____

What is your estimate of your general health? (circle one) ..... Excellent Good Fair Poor

Have you ever had an allergic reaction to:

☐ codeine ☐ penicillin ☐ erythromycin ☐ tetracycline ☐ sulfa ☐ latex

☐ local anesthetic ☐ metals (nickel, gold, silver) ☐ other _____

DO YOU HAVE or HAVE YOU EVER HAD (CIRCLE YES or NO):

- hospitalization for illness or injury ..... **Y N**
- mitral valve prolapse with regurgitation ..... **Y N**
- cardiac stent within the last 6 months ..... **Y N**
- history of infective endocarditis ..... **Y N**
- artificial heart valve, repaired heart defect ..... **Y N**
- pacemaker or defibrillator ..... **Y N**
- artificial joint prosthesis ..... **Y N**
- rheumatic or scarlet fever ..... **Y N**
- premedication required prior to dental treatment ..... **Y N**
- high or low blood pressure ..... **Y N**
- a stroke (taking blood thinner) ..... **Y N**
- anemia or blood disorder ..... **Y N**
- lung or respiratory problems ..... **Y N**
- tuberculosis ..... **Y N**
- breathing or sleep problems (i.e. snoring, sinus) ..... **Y N**
- liver disease, jaundice or hepatitis (type___) ..... **Y N**
- kidney disorder ..... **Y N**
- diabetes (type ___) ..... **Y N**
- digestive disorders (i.e. gastric reflux, ulcers) ..... **Y N**
- osteoporosis/osteopenia (taking bisphosphonates) ..... **Y N**
- arthritis ..... **Y N**
- head or neck injuries ..... **Y N**
- epilepsy, convulsions (seizures) ..... **Y N**
- cold sores and viral infections ..... **Y N**
- any lumps or swelling in the mouth ..... **Y N**
- sexually transmitted disease ..... **Y N**
- HIV/AIDS ..... **Y N**

ARE YOU:

- subject to frequent headaches ..... **Y N**
- using any form of tobacco now or previously ..... **Y N**
- FEMALE: pregnant or nursing ..... **Y N**
- presently being treated for any other illness ..... **Y N**

Describe any current medical treatment, impending surgery, or any other procedure that may possibly affect your dental treatment _____

List all medications, supplements and/or vitamins you are currently taking:

Drug	Purpose	Drug	Purpose

If I have any changes in my health status or if any medications change, I will inform the dentist and staff at the next appointment without fail.

Patient's signature _____ **Date** _____

Doctor's signature _____ **Date** _____