Medical History

Patient's Name: **Date of Birth**:

1. Have you been hospitalized during the last two years? YES NO
2. Have you been under the care of a medical doctor during the past two years? YES NO

   Physician's Name: _____ Phone #: _____

   Specialist's Name: _____ Phone #: _____

3. Do you have to pre-medicate prior to your dental appointment? YES NO
4. Are you now taking any medications and/or supplements? If yes, please list:

   _____ _____ _____

   _____ _____ _____

   _____ _____ _____

5. Are you sensitive or allergic to any medications, latex, or anesthetics? If yes, please list:

   _____ _____ _____

   _____ _____ _____

Indicate by circling which of the following you have had or have at present:

Angina	YES	NO	**Frequent Headaches**	YES	NO	**Hepatitis A (infectious)**	YES	NO
Heart Condition/Surgery	YES	NO	**Thyroid Disease**	YES	NO	**Hepatitis B and C (serum)**	YES	NO
Heart Murmur	YES	NO	**Emphysema**	YES	NO	**Intestinal Disease**	YES	NO
High Blood Pressure	YES	NO	**Asthma**	YES	NO	**Stomach Problems**	YES	NO
Pacemaker	YES	NO	**Breathing Problems**	YES	NO	**High Cholesterol**	YES	NO
Mitral Valve Prolapse	YES	NO	**Lung Disease**	YES	NO	**STI**	YES	NO
Artificial Heart Valve	YES	NO	**Tuberculosis**	YES	NO	**HIV Positive**	YES	NO
Stroke	YES	NO	**Cold Sores/Fever Blisters**	YES	NO	**AIDS**	YES	NO
Rheumatic Fever	YES	NO	**Herpes**	YES	NO	**Blood Transfusion**	YES	NO
Scarlet Fever	YES	NO	**Hypoglycemia**	YES	NO	**Hemophilia**	YES	NO
Arthritis	YES	NO	**Osteoporosis**	YES	NO	**Blood Disease**	YES	NO
Rheumatism	YES	NO	**Pain in Jaw Joints**	YES	NO	**Anemia**	YES	NO
Drug Addiction	YES	NO	**Shingles**	YES	NO	**Liver Disease**	YES	NO
Kidney Trouble	YES	NO	**Sinus Trouble**	YES	NO	**Epilepsy or Seizures**	YES	NO
Diabetes A1C:__	YES	NO	**Seasonal Allergies/Hives**	YES	NO	**Fainting or Dizziness**	YES	NO
Cancer	YES	NO	**Tumors**	YES	NO	**Nervousness/Depression**	YES	NO
Radiation Treatment	YES	NO	**Alzheimer's Disease**	YES	NO	**Artificial Joints** Date:____	YES	NO
Chemotherapy	YES	NO	**Ulcers**	YES	NO	**Autoimmune Disease**	YES	NO

Any condition(s) not listed:

_____

_____

Do you smoke? **YES** **NO** How much? Do you use a controlled substance? **YES** **NO**

FOR WOMEN ONLY:

Are you taking any birth control pills? **YES** **NO** Are you pregnant? **YES** **NO** Trimester _____

Are you nursing? **YES** **NO** Are you taking any postmenopausal hormone replacement drugs? **YES** **NO**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____ DATE _____

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