

MEDICAL HISTORY

NAME \_\_\_\_\_ M F DATE OF BIRTH \_\_\_\_\_ ACCOUNT# \_\_\_\_\_

IN THE FOLLOWING QUESTIONS, ANSWER YES OR NO, WHICHEVER APPLIES. YOUR ANSWERS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

Are you now under the care of a physician? YES  NO  If so, what is the condition being treated? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Dr. Phone # \_\_\_\_\_

Date last physical \_\_\_\_\_

DO YOU HAVE OR HAVE YOU EVER HAD:

- Anemia.....Y  N  Malignancies (Cancer).....Y  N  Stomach Ulcers.....Y  N 
Asthma.....Y  N  Radiation Therapy.....Y  N  Thyroid Disease.....Y  N 
Arthritis.....Y  N  Abnormal Heart Condition: Venereal Disease.....Y  N 
Diabetes.....Y  N  Heart Surgery.....Y  N  Sinus Condition.....Y  N 
Epilepsy.....Y  N  Mitral Valve Prolapse.....Y  N  Rheumatic Fever.....Y  N 
Fainting Spells.....Y  N  Heart Valve Replacement.....Y  N  Joint Replacement.....Y  N 
Glaucoma.....Y  N  Heart Murmur.....Y  N  Hemophilia.....Y  N 
Hepatitis: A Type.....Y  N  Heart Attack.....Y  N  Immune Deficiency or Lupus.....Y  N 
B Type.....Y  N  Pacemaker.....Y  N  Liver Disease.....Y  N 
C Type.....Y  N  Stroke.....Y  N  Women: Are you Pregnant.....Y  N 
Kidney Disease.....Y  N  Angina (chest pain).....Y  N  Take Birth Control Pills.....Y  N 
GERD/Acid Reflux...Y  N  High Blood Pressure.....Y  N  Are you Breast Feeding.....Y  N

Do you smoke or use other tobacco products? Y  N  How many a day \_\_\_\_\_ Number of years \_\_\_\_\_

Abnormal Bleeding from: a Cut \_\_\_\_\_ an Extraction \_\_\_\_\_

Drug Addiction.....Y  N  Alcoholism.....Y  N

Other \_\_\_\_\_

MEDICAL ALERT

Have you ever tested positive for AIDS.....Y  N  Have you ever required a blood transfusion?.....Y  N

If so explain the circumstances \_\_\_\_\_

Have you ever had any serious medical trouble associated with any previous dental treatment?.....Y  N

If so, explain the circumstances \_\_\_\_\_

Do you have any disease, condition, or problem not listed above? \_\_\_\_\_

Are you taking any of the following:

- Antibiotics or sulfa drugs.....Y  N 
Anticoagulants (blood thinners).....Y  N 
Medicine for high blood pressure.....Y  N 
Cortisone.....Y  N 
Aspirin.....Y  N 
Tranquilizers.....Y  N 
Insulin, tolbutamide (orinase) or similar drug.....Y  N 
Digitalis or drugs for heart trouble.....Y  N 
Nitroglycerin.....Y  N 
Have you been told antibiotics are needed prior to dental visit?.....Y  N

Are you allergic or have you reacted adversely to:

- Local anesthetics.....Y  N 
Penicillin.....Y  N 
Other antibiotics.....Y  N 
Aspirin.....Y  N 
Sulfa.....Y  N 
Codeine.....Y  N 
Latex.....Y  N 
Any other allergies? \_\_\_\_\_

List all Medications \_\_\_\_\_

The above information that I have provided is true and correct to the best of my knowledge.

Patient Signature

Date

Doctor Signature

Date