MEDICAL HISTORY

Name_____ Date of Birth_____

1. Are you in good health? ___yes ___no male___ female___
2. Has there been any change in your general health within the past 2 years? ___yes ___no
3. Are you currently under the care of a physician? ___yes ___no Date of last visit_____
   For what are you being treated? _____
   Name of Physician _____ Phone #_____
4. Have you been hospitalized within the last 5 years? ___yes ___no If yes, for what? _____
5. Do you have a prosthetic joint? ___yes ___no If so, where? _____ when was it placed? _____
6. Do you have a heart murmur? ___yes ___no Mitral valve prolapse? ___yes ___no
7. Do you have an artificial heart valve? ____yes ____no
8. Is it necessary for you to premedicate with an antibiotic prior to dental treatment? ___yes ___no
9. Is there anything you would like to discuss <u>in-private</u> with the doctor? ___yes ___no

*Please complete the following (with a checkmark √) if you have or have had:

Allergies – to medications		Shortness of breath		Neurologic disorder	
Allergies – seasonal		Swelling of feet or ankles		Seizures	
Sinus problems		Circulatory problems		Epilepsy	
Asthma		Vascular disease		Fainting or dizziness	
Emphysema		Hemophilia		Cancer or tumor	
Tuberculosis		Easy bruising		Chemotherapy	
Lung disease		Blood transfusion		Radiation treatments	
Persistent cough		Excessive bleeding from cuts		Immune system disorder	
Heart attack		Poor wound healing		Immunosuppression	
Angina / chest pain		Diabetes		HIV / AIDS	
Heart disease		Anemia		Psychiatric care	
Bypass surgery		Sickle cell disease		Emotional problems	
Heart valve surgery		Hepatitis – Type A, B, C		Anxiety	
Pacemaker		Liver disease		Recent weight change	
Rheumatic fever		Kidney disease		Sexually transmitted disease	
High blood pressure		Thyroid disorder		Venereal disease	
Low blood pressure		GERD		Oral herpes	
Stroke		Ulcer or colitis		Persistent headaches	
Glaucoma		Arthritis		Malignant hyperthermia	

Please list any disease or condition not listed above: _____

Have you ever received treatment for substance abuse? ___yes ___no alcohol abuse? ___yes ___no
Would you like help to quit? ___yes ___no
Do you use tobacco products? cigarettes __yes __no cigars or pipe __yes __no smokeless __yes __no
Would you like help to quit? ___yes ___no
Do you take any blood thinning medications on a daily basis? ____yes ____no
If yes, check all appropriate: Aspirin ___ Coumadin ___ Heparin ___ Plavix ___ Other _____
Are you allergic to or do you suffer ill effects from any of the following?
_____Penicillin _____Aspirin _____Codeine _____Household Bleach _____Dental Anesthesia
Are you aware of any other allergies that you may have? Please list:_____ _____

Are you currently taking any prescription medications? ___yes ___no If yes, please list:
_____ _____ _____ _____

Are you currently taking any over the counter medications? ___yes ___no If yes, please list:
_____ _____ _____ _____

Are you currently taking vitamins and/or herbs? ___yes ___no If yes, please list:_____

***FOR WOMEN ONLY:** Is there a possibility of pregnancy? ___yes ___no If so, what month? _____
Are you trying to get pregnant? ___yes ___no Are you currently nursing? ___yes ___no
Do you take Birth Control Pills? ___yes ___no

The above information is true to the best of my knowledge.

Responsible party for the patient:_____ Phone number _____
Relationship to patient: _____

Signature: _____Date: _____Dr. Signature_____