MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician _____

Date of last physician examination _____ Purpose _____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury	❑	❑
2. allergic reaction to	❑	❑
❑ aspirin ❑ penicillin ❑ erythromycin ❑ codeine ❑ local anesthetic ❑ fluoride ❑ metals (gold, stainless steel) ❑ any other medications_____		
❑ latex ❑ nitrous oxide ❑ sulfa drugs ❑ benzodiazepines (valium, Ativan, etc.)		
3. heart problems	❑	❑
please list _____		
4. heart murmur	❑	❑
5. rheumatic fever	❑	❑
6. scarlet fever	❑	❑
7. high blood pressure	❑	❑
8. low blood pressure	❑	❑
9. pacemaker	❑	❑
10. a stroke	❑	❑
11. artificial prosthesis	❑	❑
please list (i.e. heart valve or joints)_____		
12. anemia or other blood disorder	❑	❑
13. prolonged bleeding	❑	❑
14. emphysema	❑	❑
15. tuberculosis	❑	❑
16. asthma	❑	❑
17. bronchitis	❑	❑
18. sinus problems	❑	❑
19. kidney disease	❑	❑
20. liver disease	❑	❑
21. jaundice	❑	❑
22. thyroid or parathyroid disease	❑	❑
23. hormone deficiency	❑	❑
24. high cholesterol	❑	❑
25. diabetes	❑	❑
26. bruise easily	❑	❑
27. G.E. reflux	❑	❑
28. stomach or duodental ulcer	❑	❑
29. digestive disorders	❑	❑
30. arthritis	❑	❑
31. glaucoma	❑	❑
32. contact lenses	❑	❑
33. head or neck injuries	❑	❑
34. epilepsy, convulsions (seizures)	❑	❑
35. viral infections and cold sores	❑	❑
36. any lumps or swelling in the mouth	❑	❑
37. hives, skin rash, hay fever	❑	❑
38. sexually transmitted disease	❑	❑
39. hepatitis (type _____)	❑	❑
40. HIV / AIDS	❑	❑
41. cancer, type _____	❑	❑
42. radiation therapy	❑	❑
43. chemotherapy	❑	❑
44. emotional problems	❑	❑
45. psychiatric treatment	❑	❑
46. antidepressant medication	❑	❑
47. alcohol / drug dependency	❑	❑
48. dry mouth	❑	❑
ARE YOU:		
45. aware of a change in your general health	❑	❑
46. often exhausted or fatigued	❑	❑
47. subject to frequent headaches	❑	❑
48. a heavy smoker (1 pack or more a day)	❑	❑
49. often unhappy or depressed	❑	❑
50. easily upset or irritated	❑	❑
51. FEMALE - taking birth control pills	❑	❑
52. FEMALE - pregnant	❑	❑
44. FEMALE - breast feeding	❑	❑
53. MALE - Prostate disorders	❑	❑

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment, (include current illnesses, previous surgeries and hospitalizations) _____

_____

List any medications taken within the last two years _____

_____

List any other drugs taken in the past 2 years (steroids, cocaine, recreational drugs, herbal remedies and vitamins...)

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

I certify that I have read & understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient's Signature: _____ Date: _____

Doctor's Remarks: _____

_____ Doctor's Signature _____