MEDICAL HISTORY

Name: _____

Medical Doctor: _____

Specialist: _____

Specialist: _____

Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

List all medications that you are currently taking:

_____

_____

_____

_____

_____

_____

Are you allergic to any of the following?

Penicillin	☐ Y ☐ N	Tetracycline	☐ Y ☐ N
Aspirin	☐ Y ☐ N	Dental Anesthetics	☐ Y ☐ N
Erythromycin	☐ Y ☐ N	Codeine	☐ Y ☐ N
Latex	☐ Y ☐ N	List other: _____	

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Heart Attack	☐ Y ☐ N	Mitral Valve Prolapse	☐ Y ☐ N
Stroke	☐ Y ☐ N	Kidney/Liver Problems	☐ Y ☐ N
Cancer	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N
High Blood Pressure	☐ Y ☐ N	Artificial Valves	☐ Y ☐ N
Heart Surgery	☐ Y ☐ N	Artificial Joints	☐ Y ☐ N
Pacemaker	☐ Y ☐ N	Hepatitis	☐ Y ☐ N

DISEASE/MEDICAL PROBLEMS CONT.:

Abnormal Bleeding	☐ Y ☐ N	Radiation Treatment	☐ Y ☐ N
Hemophilia	☐ Y ☐ N	Chemotherapy	☐ Y ☐ N
Anemia	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N
Blood Transfusion	☐ Y ☐ N	Shingles	☐ Y ☐ N
Tuberculosis (TB)	☐ Y ☐ N	Fever Blisters	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Ulcers/Colitis	☐ Y ☐ N
Convulsions/Epilepsy	☐ Y ☐ N	Severe Headaches	☐ Y ☐ N
Emphysema	☐ Y ☐ N	Fainting Spells	☐ Y ☐ N
Asthma	☐ Y ☐ N	Arthritis	☐ Y ☐ N
Difficulty Breathing	☐ Y ☐ N	Drug/Alcohol Abuse	☐ Y ☐ N
Sinus Problems	☐ Y ☐ N	Tobacco Use	☐ Y ☐ N
Glaucoma	☐ Y ☐ N	Psychiatric Problems	☐ Y ☐ N
Osteoporosis		HIV+/AIDS	☐ Y ☐ N
Drug Treatment	☐ Y ☐ N	Venereal Disease	☐ Y ☐ N
Rheumatic Fever	☐ Y ☐ N	Other: _____	

FOR WOMEN

Are you taking birth control pills?	☐ Y ☐ N
Are you pregnant? Week#_____	☐ Y ☐ N
Are you nursing?	☐ Y ☐ N

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental office staff to perform the necessary dental services I may need. I understand the use of anesthetic agents embodies a certain risk.

_____

Signature Date

FOR OFFICE USE ONLY

1. Date:_____/_____/_____ Initial: _____ Comments: _____

_____

2. Date:_____/_____/_____ Initial: _____ Comments: _____

_____

3. Date:_____/_____/_____ Initial: _____ Comments: _____

_____

4. Date:_____/_____/_____ Initial: _____ Comments: _____

_____

5. Date:_____/_____/_____ Initial: _____ Comments: _____

_____

6. Date:_____/_____/_____ Initial: _____ Comments: _____

_____