

MEDICAL HISTORY FORM

NAME: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you had any surgeries since your last visit: Yes No

If yes, for what: \_\_\_\_\_

Medications that you are currently taking, including herbal remedies: \_\_\_\_\_

Do you need antibiotic premedication for dental work: Yes No

Have you ever had or do you presently have:

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| Heart Attack .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Surgery .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Pacemaker .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Heart Valve .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Joints (knee, Hip, etc) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of replacement _____                |                          |                          |
| Congenital Heart Defect .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV positive .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis A B C .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Hemophilia .....                         | <input type="checkbox"/> | <input type="checkbox"/> |

- |                            | Yes                      | No                       |
|----------------------------|--------------------------|--------------------------|
| Drug Addiction .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Problems .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| Bruise Easily .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy or Seizures ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| Type _____                 |                          |                          |
| Emphysema .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay Fever .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus Problems .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Disease .....      | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis .....         | <input type="checkbox"/> | <input type="checkbox"/> |

Any other health issue that you feel we should know: \_\_\_\_\_

Are you allergic or have you reacted adversely to any of the following: Please check either YES or NO.

- |                   | Yes                      | No                       |                         | Yes                      | No                       |                         | Yes                      | No                       |
|-------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|
| Aspirin .....     | <input type="checkbox"/> | <input type="checkbox"/> | Metals.....             | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa drugs .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| Tylenol .....     | <input type="checkbox"/> | <input type="checkbox"/> | Latex (Rubber) .....    | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Nut allergy ..... | <input type="checkbox"/> | <input type="checkbox"/> | Antibiotic allergy..... | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____            |                          |                          |
|                   |                          |                          | Please List: _____      |                          |                          |                         |                          |                          |

Are you nervous about dental visits: Yes No

For Women only:	Yes	No		Yes	No		Yes	No
Are you pregnant .....	<input type="checkbox"/>	<input type="checkbox"/>	Nursing: .....	<input type="checkbox"/>	<input type="checkbox"/>	On Birth Control Medication .....	<input type="checkbox"/>	<input type="checkbox"/>

I certify that these statements concerning my health are correct to the best of my knowledge and understand that incorrect answers could be affected by dental treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_