Medical History Form

Patient Name: _____ Date of Birth: _____ Sex: ◯ Male ◯ Female

Are you under the care of a physician?
Physician Name: _____Phone number (including area code): _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ◯ Yes ◯ No
If yes, explain: _____
Are you taking or have you recently taken any prescription or over the counter medicine(s)? ◯ Yes ◯ No
If so, please list all: _____
Have you ever had any orthopedic total joint replacement? ◯ Yes ◯ No Date of replacement: _____
Do you use controlled substances (drugs)? ◯ Yes ◯ No
Do you use tobacco (smoking, snuff, chew, bidis)? ◯ Yes ◯ No

WOMEN ONLY - Are you:
Pregnant? ◯ Yes ◯ No If yes, number of weeks?_____ Nursing: ◯ Yes ◯ No
Taking birth control pills or hormonal replacement? ◯ Yes ◯ No

Allergies, are you allergic to or have you had any reaction to:

Local anesthetics…… ◯ Yes ◯ No	Iodine: ◯ Yes ◯ No	Aspirin: ◯ Yes ◯ No	Animals: ◯ Yes ◯ No
Hay fever/seasonal…. ◯ Yes ◯ No	Food: ◯ Yes ◯ No	Sulfa Drugs: ◯ Yes ◯ No	Metals: ◯ Yes ◯ No
Latex (rubber)…….. ◯ Yes ◯ No	Codeine or other narcotics ◯ Yes ◯ No	Barbiturates, sedatives or sleeping pills: ◯ Yes ◯ No	

Other: ◯ Yes ◯ No If other, please specify_____

Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve ….. ◯ Yes ◯ No	Congenital heart disease (CHD) ◯ Yes ◯ No	Angina ◯ Yes ◯ No
Cardiovascular Disease …….. ◯ Yes ◯ No	Severe headaches/migraines ◯ Yes ◯ No	Anemia ◯ Yes ◯ No
Blood Transfusion…….. ◯ Yes ◯ No	Arteriosclerosis ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No
If yes, date of transfusion: _____	Arthritis ◯ Yes ◯ No	Asthma ◯ Yes ◯ No
Congestive Heart Failure …….. ◯ Yes ◯ No	Damaged heart valves ◯ Yes ◯ No	AIDS or HIV ◯ Yes ◯ No
Heart attack…….. ◯ Yes ◯ No	Autoimmune disease ◯ Yes ◯ No	Heart murmur ◯ Yes ◯ No
Low blood pressure ……..…… ◯ Yes ◯ No	Rheumatoid arthritis ◯ Yes ◯ No	Pacemaker ◯ Yes ◯ No
High blood pressure ……..… ◯ Yes ◯ No	Mitral valve prolapse ◯ Yes ◯ No	Rheumatic fever ◯ Yes ◯ No
Rheumatic fever …… ◯ Yes ◯ No	Rheumatic heart disease ◯ Yes ◯ No	Sinus trouble ◯ Yes ◯ No
Tuberculosis ……..….. ◯ Yes ◯ No	Abnormal bleeding ◯ Yes ◯ No	Chronic pain ◯ Yes ◯ No
Sleep disorder …….. ◯ Yes ◯ No	Diabetes Type I or II ◯ Yes ◯ No	Eating disorder ◯ Yes ◯ No
G.E. Reflux/persistent heartburn … ◯ Yes ◯ No	Mental health disorders ◯ Yes ◯ No	Malnutrition ◯ Yes ◯ No
Gastrointestinal disease…… ◯ Yes ◯ No	Kidney problems ◯ Yes ◯ No	Thyroid problems ◯ Yes ◯ No
Persistent swollen glands in neck .. ◯ Yes ◯ No	Severe or rapid weight loss ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Fainting spells or seizures…….. ◯ Yes ◯ No	Epilepsy ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No
Persistent swollen glands in neck… ◯ Yes ◯ No	Neurological disorders ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No
Hepatitis, jaundice or liver disease.. ◯ Yes ◯ No	Sexually transmitted disease ◯ Yes ◯ No	Neurological disorders ◯ Yes ◯ No

Cancer/Chemotherapy/Radiation Treatment ◯ Yes ◯ No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ◯ Yes ◯ No
Name of physician or dentist making recommendation (include phone number): _____
Do you have any disease, condition, or problem not listed above that you think I should know about? ◯ Yes ◯ No
If yes, please explain: _____

_____

_____ _____
Signature of Patient/Legal Guardian Date