



MEDICAL HISTORY

Patient's Name: _____
Last First Initial Date of Birth

COMMENTS

CIRCLE THE APPROPRIATE ANSWER, IF YOU DO NOT KNOW THE CORRECT ANSWER, PLEASE WRITE "DO NOT KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name _____
City _____
Telephone _____
2. Are you under a physician's care? YES NO
Since when _____ Why _____
3. When was your last complete physical exam? _____
4. **Are you taking any medication or substances?** YES NO
If yes please list medications in the comments section
5. Do you routinely take health related substances? (vitamins, herbal supplements etc.) YES NO
6. **Are you allergic to any medications or substances? (Please list)** YES NO
7. Do you have any other allergies or hives? YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or any other medications? YES NO
9. Are you sensitive to any metals or latex? YES NO
10. Are you pregnant or suspect you may be? YES NO
11. Do you use any birth control medications? YES NO
12. Have you ever been treated for or been told you might have heart disease? YES NO
13. Do you have a pacemaker or an artificial heart valve implant? YES NO
14. Have you ever had rheumatic fever? YES NO
15. Are you aware of any heart murmurs? YES NO
16. Have you been told to take antibiotics before dental treatment? YES NO
17. Do you have high or low blood pressure? (Please circle) YES NO
18. Have you ever had a serious illness or major surgery? YES NO
If so, explain _____
19. Have you ever had radiation treatment or chemotherapy? YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? YES NO
21. Do you have any artificial joints/prosthesis? YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc,? YES NO
23. Have you ever bleed excessively after being cut or injured? YES NO
24. Do you have any stomach problems? YES NO
25. Do you have any liver problems? YES NO
26. Do you have any kidney problems? YES NO
27. Are you diabetic? YES NO
28. Do you have fainting or dizzy spells? YES NO
29. Do you have asthma? YES NO
30. Do you have epilepsy or seizure disorders? YES NO
31. Have you tested HIV positive? YES NO
32. Do you have AIDS? YES NO
33. Have you had or do test positive for hepatitis? YES NO
34. Do you or have you had T.B.? YES NO
35. Do you smoke, chew, use snuff or any other forms of tobacco? YES NO
36. Do you regularly consume more than one or two alcoholic beverages a day? YES NO
37. Do you habitually use controlled substances? YES NO
38. Have you had psychiatric treatment? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____