MEDICAL HISTORY

Name____Date__________

1. When was your last physical examination? ____________________________________
2. Physician's name ______________________________Telephone ___________________

3. Has your doctor ever told you to take antibiotics before dental treatment? Y/N
4. Are you currently taking *ANY* medication including over the counter or herbal treatment?
Circle Yes or NO If Yes please list all medication__________________________________
____
____

Do you have or have you had any of the following? (Circle Yes or No)

Yes No Damaged heart valve/heart murmur
Yes No Mitral valve prolapse
Yes No Heart valve replacement
Yes No Pacemaker
Yes No Artificial Joint or pins or plates
Yes No Hepatitis A, B, C or liver disease
Yes No Tuberculosis
Yes No HIV / AIDS
Yes No Diabetes
Yes No History of addiction or substance abuse
Yes No Bad reaction to local or general anesthetic
Yes No Abnormal bleeding
Yes No Glaucoma
Yes No High blood pressure
Yes No Cancer
Yes No Cortisone treatment
Yes No Emphysema
Yes No Epilepsy
Yes No Venereal disease
Yes No Organ replacement
Yes No Radiation therapy
Yes No Psychiatric medicine/therapy

Heart Surgeries? _________________________________
Yes/No Do you have any disease or condition not listed that you think I should know about? If yes, please explain____
yes no Would you like to discuss your medical history privately with the doctor?

Are you allergic to any of the following?

Yes No Local anesthetics
Yes No Penicillin
Yes No Sulfa drugs
Yes No Sedatives
Yes No Iodine
Yes No Latex

List others_____________________________________

Woman
Yes No Are you pregnant? months ____
Yes No Nursing

What concerns you most about your mouth?____

Have you ever been told you have or been treated for gum disease?_________________________
Do you snore or have sleep apnea? Yes no

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. If there is any change in my medical status I will inform the dentist.
I authorize the doctor and /or provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian Signature ____