MEDICAL HISTORY

Information about your health will be held confidential. Your general health affects oral health and influences your care.

Patient Name: _____ Date: _____

(Please circle your answer)

Y N 1. Are you in good health?
Y N 2. Are you under the care of a physician? Reason:_____
Name & Address of Physician_____
Y N 3. Have you had surgery or been hospitalized in the last 5 years? Explain:_____
Y N 4. Are you taking any medication (*prescribed* or *non-prescribed)* or drug(s) at this time?
Names of Medications:_____
_____
_____
Y N 5. Have you ever had an allergic or unusual reaction to any medication? (penicillin, sulfa drugs, etc.)
Names of Medications:_____
Y N 6. Have you ever had any trouble with prolonged bleeding after dental extractions, surgery, or trauma?
Y N 7. Have you ever required a blood transfusion? Reason & Date:_____
Y N 8. Have you taken cortisone or steroids in the last 2 years? What & How Long:_____
Y N 9. Are you required to take antibiotics prior to dental treatment? Reason:_____
Y N 10. Do you usually have problems getting numb for dental treatment?
Y N 11. Have you ever had any serious trouble with dental treatment? Explain:_____
12. **<u>WOMEN ONLY:</u> (please circle answer)**
Y N Are you pregnant? How Long?:_____
Y N Are you breast feeding?
Y N Are you taking birth control pills? *If yes, be advised that if you take antibiotics, an alternate method of birth control is recommended.*

13. Do you <u>NOW HAVE</u> or <u>HAVE YOU EVER HAD</u> the following? (please circle answer)

Y N Rheumatic Fever*	Y N Diabetes	Y N Arthritis
Y N Mitral Valve Prolapse*	Y N Anemia (incl. Sickle Cell)	Y N Stomach or Intestinal Ulcers
Y N Heart Murmur*	Y N Hemophilia	Y N Cancer/Tumor/Cysts
Y N Artificial Heart Valve*	Y N Blood Disorder/Leukemia	Y N Chemotherapy/Radiation Treatment
Y N Joint Prosthesis (Hip,Knee,etc)*	Y N Lung Disease/Emphysema	Y N Sexually Transmitted Disease
Y N Heart Pacemaker	Y N Asthma	Y N Herpes
Y N Angina or Chest Pains	Y N Tuberculosis	Y N AIDS or HIV Positive
Y N Heart Attack/Disease or Surgery	Y N Liver Disease or Jaundice	Y N Epilepsy or Seizures
Y N Stroke	Y N Hepatitis A, B, or C (circle)	Y N Glaucoma
Y N High Blood Pressure	Y N Kidney Disease	Y N Drug or Alcohol Problem
Y N Cardiovascular Stent	Y N Thyroid Disease	Y N Psychological Disorder
Y N Hayfever or Sinus Trouble	Y N Shingles	Y N Latex Allergy
Y N Pain in Jaw Joints (TMJ)	Y N Clench or Grind Teeth	

Do you have any disease, problem, or condition not listed above that you think I should know about? Y N (circle one)
Explain: _____

All of the above information is true and correct to the best of my knowledge. If I have any changes in my health or medications I will inform the doctor prior to treatment at the next appointment without fail.

_____
Signature of Patient, Parent or Guardian Date

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