Medical History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you have or have you ever been treated for:

	YES	NO
HEART MURMUR*	❑	❑
MITRAL VALVE PROLAPSE*	❑	❑
HEART VALVE DEFECT*	❑	❑
HEART VALVE REPLACEMENT*	❑	❑
ANGINA	❑	❑
STROKE	❑	❑
HEART ATTACK	❑	❑
BYPASS	❑	❑
PACEMAKER	❑	❑
OTHER HEART PROBLEMS	❑	❑
RHEUMATIC FEVER*	❑	❑
ARTIFICAL JOINT (HIP / KNEE)*	❑	❑
HIGH BLOOD PRESSURE	❑	❑
LOW BLOOD PRESSURE	❑	❑
ANEMIA	❑	❑
HEMOPHILIA	❑	❑
SICKLE CELL TRAIT	❑	❑
BLOOD TRANSFUSIONS	❑	❑
OTHER BLOOD DISORDERS	❑	❑

	YES	NO
DO YOU SMOKE	❑	❑
ASTHMA	❑	❑
BRONCHITIS	❑	❑
EMPHYSEMA	❑	❑
TUBERCULOSIS	❑	❑
SINUS TROUBLE	❑	❑
OTHER LUNG/BREATHING PROBLEMS	❑	❑
DIFFICULTY IN HEALING	❑	❑
DIABETES	❑	❑
THYROID PROBLEMS	❑	❑
ADRENAL/PITUITARY PROBLEMS	❑	❑
LIVER PROBLEMS / DYSFUNCTION	❑	❑
HEPATITIS / JAUNDICE	❑	❑
KIDNEY PROBLEMS / DYSFUNCTION	❑	❑
STOMACH TROUBLE / ULCERS	❑	❑
NERVOUS OR MENTAL DISORDER	❑	❑
EPILEPSY OR SEIZURES	❑	❑
ALCOHOLISM	❑	❑
DRUG ABUSE	❑	❑

	YES	NO
ALLERGIC REACTION (HIVES / SWELLING) TO:		
PENICILLIN	❑	❑
ERYTHROMYCIN	❑	❑
SULFA	❑	❑
CODEINE	❑	❑
ASPIRIN	❑	❑
LATEX	❑	❑
LOCAL ANESTHETIC (NOVOCAIN)	❑	❑
ALLERGIES TO OTHER MEDICATIONS OR SUBSTANCES? Please list: ______________________	❑	❑
CANCER / TUMOR	❑	❑
OTHER GROWTHS	❑	❑
CHEMOTHERAPY / RADIATION THERAPY	❑	❑
SEXUALLY TRANSMITTED DISEASES	❑	❑
OTHER INFECTIOUS DISEASES	❑	❑
HIV / AIDS	❑	❑
ARE YOU PREGNANT?	❑	❑

*Do you need to take antibiotic premedication prior to dental appointments? ❑ YES ❑ NO ❑ DON'T KNOW Name of antibiotic: ______________

Are you presently taking any medications, pills, or tonics? ❑ YES ❑ NO Name: ______________ For: ______________
(i.e., blood pressure, birth control, steroids, hormones)
______________ For: ______________
______________ For: ______________
______________ For: ______________

Are you currently being treated by a physician? ❑ YES ❑ NO Why? ______________

Physician's name and phone: ______________

Is there any medical condition or health problem that has not been noted above? ❑ YES ❑ NO Explain: ______________

I certify that the above information is complete and accurate to the best of my knowledge. I will inform the dentist of any changes in my health status or my medications. ______________ DATE X ______________ PATIENT / GUARDIAN SIGNATURE

Initial Review of Patient Medical History

INTERVIEWER NOTES ______________

Medical Alert Recommended: ❑ YES ❑ NO

Premedication Recommended: ❑ YES ❑ NO

Yearly review of Patient Medical History

NO CHANGE	CHANGE	LIST:	DATE	PATIENT / GUARDIAN SIGNATURE	DOCTOR / HYGIENIST SIGNATURE
❑	❑				
❑	❑				
❑	❑				
❑	❑				
❑	❑				
❑	❑				

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