

MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

PHYSICIAN'S NAME: _____ PHONE: _____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

- | | | | |
|-------|---|-----|----|
| 1. | Do you consider yourself to be in good health? | YES | NO |
| 2. | Are you now or have you been under a physician's care within the past year?
<u>If Yes, specify condition being treated</u> _____ | YES | NO |
| 3. | Do you take any medications, including birth control pills?
Please specify name and purpose of medications: _____ | YES | NO |
| <hr/> | | | |
| 4. | Do you have or have you ever had any heart or blood problems? | YES | NO |
| 5. | Have you ever been told that you have a heart murmur? | YES | NO |
| 6. | Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? | YES | NO |
| 7. | Do you have or have you ever had high blood pressure? | YES | NO |
| 8. | Do you bleed or bruise easily? | YES | NO |
| 9. | Have you ever been diagnosed as being HIV positive or having AIDS? | YES | NO |
| 10. | Have you ever had hepatitis or liver disease? | YES | NO |
| 11. | Have you ever had: rheumaticfever _____; asthma _____; any blood disorder _____; diabetes _____; rheumatism _____; arthritis _____; tuberculosis _____; venereal disease _____; heart attack _____; kidney disease _____; immune system disorders _____; other disease _____?
<u>If so, specify:</u> _____ | | |
| 12. | Have you ever had an unusual reaction or are you allergic to any of the following drugs: Penicillin _____; Aspirin _____; Acetaminophen _____; Ibuprofen _____; Codeine _____; Barbiturates _____; Sulfa Drugs _____; Other _____ | | |
| 13. | Are you subject to fainting? | YES | NO |
| 14. | Have you ever had any severe reaction to dental treatment or local anesthetics? | YES | NO |
| 15. | Are you allergic to any local anesthetic? | YES | NO |
| 16. | Do you have any other allergies? <u>If Yes, please describe:</u> _____ | YES | NO |
| <hr/> | | | |
| 17. | Have you ever had a nervous breakdown or undergone psychiatric treatment? | YES | NO |
| 18. | Have you ever received counseling for use of alcohol and/or prescription drugs? | YES | NO |
| 19. | Women: Are you pregnant? | YES | NO |
| 20. | Are you now in pain? | YES | NO |
| 21. | How long ago did you last see a dentist? _____ | | |
| 22. | Who was your previous dentist? _____ | | |
| 23. | Do you think that your teeth are affecting your general health in any way? | YES | NO |
| 24. | Do you have or have you ever had bleeding or sensitive gums? | YES | NO |
| 25. | | | |
| 26. | | | |
| 27. | Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? | YES | NO |

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I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature _____ Date _____

(Patient, legal guardian or authorized agent of patient)