

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Patient

Address _____ Date of Birth _____
 _____ Weight _____
 _____ Height _____ Male
 _____ SSN _____ Female
 Phone _____ (home)
 _____ (work)
 _____ (cell)

List medications including vitamins, herbal supplements, natural products or over-the-counter drugs taken routinely.

MEDICAL HISTORY

Physician Name _____
 Address _____

Are you currently under the care of a physician? Y N
 If yes, for what reason? _____

Are you presently taking any medications/drugs/pills? Y N

ALLERGIES

Are you allergic (or have an adverse reaction) to: *Check all that apply or check none.*

- Penicillin Codeine Local Anesthetic None
 Aspirin Other Antibiotics Other Medications or Substances

Are you sensitive or allergic to latex? Have you experienced itching, rash or wheezing after using latex gloves or handling a balloon? Have you had any unusual or unexplained reactions during a surgical procedure?
 Yes No Explain. _____

Do you have, or have you ever had any of the following (yes or no)?

1	Heart Disease/Surgery	<input type="radio"/> Y <input type="radio"/> N	31	Leukemia	<input type="radio"/> Y <input type="radio"/> N
2	Heart Murmur	<input type="radio"/> Y <input type="radio"/> N	32	Prolonged Bleeding	<input type="radio"/> Y <input type="radio"/> N
3	Heart Pacemaker	<input type="radio"/> Y <input type="radio"/> N	33	Hemophilia	<input type="radio"/> Y <input type="radio"/> N
4	Rheumatic Fever	<input type="radio"/> Y <input type="radio"/> N	34	Sickle Cell Disease	<input type="radio"/> Y <input type="radio"/> N
5	Rheumatic Heart Disease	<input type="radio"/> Y <input type="radio"/> N	35	Cancer	<input type="radio"/> Y <input type="radio"/> N
6	Congenital Heart Disease	<input type="radio"/> Y <input type="radio"/> N	36	Tumors	<input type="radio"/> Y <input type="radio"/> N
7	Artificial Heart Valve	<input type="radio"/> Y <input type="radio"/> N	37	Chemotherapy	<input type="radio"/> Y <input type="radio"/> N
8	Mitral Valve Prolapse	<input type="radio"/> Y <input type="radio"/> N	38	Radiation Therapy	<input type="radio"/> Y <input type="radio"/> N
9	Abnormal Blood Pressure	<input type="radio"/> Y <input type="radio"/> N	39	Neurological Disorders	<input type="radio"/> Y <input type="radio"/> N
10	Learning Disability	<input type="radio"/> Y <input type="radio"/> N	40	Epilepsy	<input type="radio"/> Y <input type="radio"/> N
11	Psychiatric Care	<input type="radio"/> Y <input type="radio"/> N	41	Stroke	<input type="radio"/> Y <input type="radio"/> N
12	Anorexia	<input type="radio"/> Y <input type="radio"/> N	42	Arthritis/Rheumatism	<input type="radio"/> Y <input type="radio"/> N
13	Bulimia	<input type="radio"/> Y <input type="radio"/> N	43	Prosthetic Implants	<input type="radio"/> Y <input type="radio"/> N
14	Lung Disease	<input type="radio"/> Y <input type="radio"/> N	44	Artificial Joints	<input type="radio"/> Y <input type="radio"/> N
15	Tuberculosis	<input type="radio"/> Y <input type="radio"/> N	45	Liver Disease	<input type="radio"/> Y <input type="radio"/> N
16	Asthma	<input type="radio"/> Y <input type="radio"/> N	46	Hepatitis (type A)	<input type="radio"/> Y <input type="radio"/> N
17	Shortness of Breath	<input type="radio"/> Y <input type="radio"/> N		Hepatitis (type B)	<input type="radio"/> Y <input type="radio"/> N
18	Respiratory Ailments	<input type="radio"/> Y <input type="radio"/> N		Hepatitis (type C)	<input type="radio"/> Y <input type="radio"/> N
19	Emphysema	<input type="radio"/> Y <input type="radio"/> N	47	Ulcers	<input type="radio"/> Y <input type="radio"/> N
20	Sinus Trouble	<input type="radio"/> Y <input type="radio"/> N	48	Stomach Disorders	<input type="radio"/> Y <input type="radio"/> N
21	Diabetes	<input type="radio"/> Y <input type="radio"/> N	49	GERD (gastric reflux)	<input type="radio"/> Y <input type="radio"/> N
22	Thyroid Problems	<input type="radio"/> Y <input type="radio"/> N	50	Hearing Impaired	<input type="radio"/> Y <input type="radio"/> N
24	Venereal Disease	<input type="radio"/> Y <input type="radio"/> N	51	Glaucoma	<input type="radio"/> Y <input type="radio"/> N
25	HIV Positive/AIDS/ARC	<input type="radio"/> Y <input type="radio"/> N	52	Cortisone Medicine	<input type="radio"/> Y <input type="radio"/> N
26	Alcohol Addiction	<input type="radio"/> Y <input type="radio"/> N	53	Fainting Spells	<input type="radio"/> Y <input type="radio"/> N
27	Drug Addiction	<input type="radio"/> Y <input type="radio"/> N	54	Organ Transplant	<input type="radio"/> Y <input type="radio"/> N
28	Chemical Dependency	<input type="radio"/> Y <input type="radio"/> N	55	Removal of Spleen	<input type="radio"/> Y <input type="radio"/> N
29	Blood Disorders	<input type="radio"/> Y <input type="radio"/> N	56	Osteoporosis	<input type="radio"/> Y <input type="radio"/> N
30	Anemia	<input type="radio"/> Y <input type="radio"/> N			

Doctor comments:

Do you currently smoke or use the following tobacco products?

- Cigarettes Pipe None
 Cigars Chew

Do you drink alcoholic beverages? Y N

How much?

How often?

Do you want to speak to the doctor
privately about any problems? Y N

Have you had any other serious illness, hospitalization or accident?

Yes No Explain. _____

WOMEN

Are you pregnant? Y N

Do you take any birth
control medications? Y N

If yes, please note.

BP Screening

I understand 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. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.