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MEDICAL HISTORY

PATIENT NAME _____ DATE OF BIRTH _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of Family Doctor: _____ Phone#: _____

Name of Medical Specialist: _____ Phone #: _____

Date of Last Physical Examination: _____

Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? ☐ *Yes* ☐ *No* ☐ *Not sure / Maybe*

_____

_____

Are you taking any medications, non-prescription drugs or herbal supplements or any kind? If yes, please list. ☐ *Yes* ☐ *No* ☐ *Not sure / Maybe*

_____

_____

Have you ever had an allergic or bad reaction to any of the following:

☐ aspirin, codeine	☐ acetaminophen, ibuprofen	☐ penicillin	☐ erythromycin
☐ tetracycline	☐ sulfa	☐ local anesthetic	☐ fluoride
☐ chlorhexidine (CHX)	☐ iodine	☐ metals (nickel, gold, silver etc.)	☐ latex
☐ nuts	☐ fruit	☐ milk	☐ red dye

Other: _____

Do you have or have you ever had asthma? ☐ *Yes* ☐ *No* ☐ *Not sure / Maybe*

_____

Do you have or have you ever had any heart or blood pressure problems?

☐ *Yes* ☐ *No* ☐ *Not sure / Maybe*

_____

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Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (E.G. infective endocarditis), a heart condition from birth (E.G. congenital heart disease) or heart transplant? ☐*Yes* ☐*No* ☐*Not sure / Maybe*

Have you ever taken medications or had injections for osteoporosis or low bone density (E.G. FOSAMEX, ACTONEL)? If yes, how long has it been? ☐*Yes* ☐*No* ☐*Not sure / Maybe*

Do you have a bleeding disorder? Are you on blood thinners (E.G. COUMADIN, PLAVIX, ASA/ASPIRIN)? ☐*Yes* ☐*No* ☐*Not sure / Maybe*

Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
☐*Yes* ☐*No* ☐*Not sure / Maybe*

Do you have or have you ever had any of the following? (Please check)

☐ Chest pain, angina	☐ Heart attack	☐ Stroke	☐ Shortness of breath
☐ Rheumatic fever	☐ Mitral valve prolapse	☐ Heart murmur	☐ Pacemaker
☐ Lung disease	☐ Tuberculosis	☐ Cancer	☐ Steroid therapy
☐ Diabetes	☐ Stomach ulcers	☐ Arthritis	☐ Seizures (epilepsy)
☐ Kidney disease	☐ Thyroid disease	☐ Drug/alcohol dependency	☐ Jaundice
☐ Hepatitis, liver disease	☐ Prosthetic/artificial joint	☐ AIDS	☐ HIV
☐ Radiotherapy	☐ Leukemia	☐ Chemotherapy	☐ Smoking/chewing tobacco

Note: _____

Are there any conditions or diseases not listed above that you have or have had? If so, what?
☐*Yes* ☐*No* ☐*Not sure / Maybe*

Are there any diseases or medical problems that run in your family? (E.G. Diabetes, cancer or heart disease) ☐*Yes* ☐*No* ☐*Not sure / Maybe*

FOR WOMAN ONLY: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? ☐*Yes* ☐*No* ☐*Not sure / Maybe*

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____