MEDICAL HISTORY FORM

Patient's Name (Please Print)	**Date**

Height __________ Weight __________

For the following questions, circle yes or no, whichever apply. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Yes No Are you in good health?
Yes No Has there been any change in your general health within the past year?
Your last physical examination was on: ______________________
Yes No Are you now under the care of a physician?
If so, what condition is being treated? Name and address of physician(s):
____
Yes No Have you had any serious illness, operation or been hospitalized in the past five years? ______________________
Yes No Are you or have you ever taken a biophosphonate medication (eg. Fosamax, Actonel, Boniva, Zometa, etc.)
Yes No Have you ever been instructed to take an antibiotic prior to dental treatment?

Do you have or have you had any of the following diseases or problems?

Yes No Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis or stroke)?
Yes No Tetralogy of fallot
Yes No Coronary palliative shunt or conduit repairs
Yes No Transposition of the Great Arteries
Yes No Single heart ventricle

Yes No Inborn heart defects
Yes No Cardiac pacemaker
Yes No Chest pain upon exertion
Yes No Low blood pressure (hypotension)
Yes No High blood pressure (hypertension)
Yes No Shortness of breath
Yes No Swelling in ankles
Yes No Emphysema, bronchitis, etc.
Yes No Asthma or hay fever
Yes No Cough that produces blood
Yes No Persistent cough
Yes No Sinus trouble
Yes No Tuberculosis
Yes No Allergy to local anesthetics
Yes No Penicillin or other antibiotic allergy
Yes No Sulfa drug allergy
Yes No Barbiturates or sedatives allergy
Yes No Aspirin sensitivity
Yes No Iodine allergy
Yes No Codeine or other narcotic allergy
Yes No Latex Allergy
Yes No Other allergies: ______________________
Yes No Immune system problems

Yes No Hepatitis, jaundice or liver disease
Yes No AIDS or HIV infection
Yes No Sexually transmitted disease
Yes No Persistent diarrhea or recent weight loss
Yes No Stomach ulcer or hyper acidity
Yes No Epilepsy or other neurological disease
Yes No Fainting spells or seizures
Yes No Blood disorder or anemia
Yes No Abnormal bleeding
Yes No Growth or tumor: ________________
Yes No Cancer: ________________________
Yes No Diabetes
Yes No Thyroid problems
Yes No Kidney trouble
Yes No Artificial joint: __________________
Yes No Arthritis or painful swollen joints
Yes No Contact lenses

Women:
Yes No Pregnant
Yes No Birth Control Pills
Yes No Nursing

Yes No Do you have any disease, condition or problem not listed above that you think we should know about?
____
____
____
____

Yes No Are you taking any medications including non-prescription medication?
If so, what medication(s) are you taking? (Please use the bottom of this page if you need more space)

Medication:	Dose:
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

I certify that I have read and understand the information on the reverse side. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Patient's Signature (Guardian for Minors) **Date**

Additional signatures for future appointments:

Patient's Signature (Guardian for Minors) **Date**

Patient's Signature (Guardian for Minors) **Date**

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