

## **MEDICAL HISTORY**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

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?  | YES | NO |
|     | <u>If Yes, specify condition being treated</u> _____   |     |    |
| 3.  | Do you take any medications, including birth control pills?  | YES | NO |
|     | Please specify name and purpose of medications: _____  |     |    |
|     | _____  |     |    |
| 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?  |     |    |
| 11. | Have you ever had: rheumatic fever _____; asthma _____; any blood disorder _____; diabetes _____; rheumatism _____; arthritis _____; tuberculosis _____; venereal disease _____; heart attack _____; kidney disease _____; immune system disorders _____; other disease _____? | YES | NO |
|     | <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 _____  | YES | NO |
| 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 |
| 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. | Have you ever taken Phen-Fen or similar appetite suppressants?   | YES | NO |
|     | <u>If Yes, have you seen your physician or cardiologist for a cardiac evaluation?</u>  | YES | NO |
| 26. | Have you ever used or are you now using tobacco or alcohol?  | YES | NO |

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)

(Rev. 4/05)