Medical History

Physician's name..... Phone (.....) ..... Last visit……

Have there been any changes in your general health within the past year?.....**Y** **N**

If so, please explain…….....

Have you had any serious illness or operation?.....**Y** **N**

If so, please explain (include dates)…….....

Have you ever had any surgical prostheses? (joint replacement or implants)..**Y** **N**

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

Rheumatic Fever……..……..**Y** **N**
Congenital Heart Defect……..**Y** **N**
Angina or Heart Attack……..……**Y** **N**
Heart Murmurs……..……**Y** **N**
Congestive Heart Failure……..……**Y** **N**
Heart Surgery or Pacemaker……..……**Y** **N**
High Blood Pressure……..……**Y** **N**
Low Blood Pressure……..……**Y** **N**
Stroke……..……**Y** **N**
Asthma or Bronchitis……..……**Y** **N**
Emphysema……..……..**Y** **N**
Hay Fever or Sinusitis……..…… **Y** **N**
Diabetes……..……**Y** **N**
Hyperthyroidism……..……**Y** **N**
Hypothyroidism……..……**Y** **N**
Anemia……..……**Y** **N**
Do you bleed excessively when cut.....**Y** **N**

Do you have an allergy or reaction to any of the following?

Latex Allergy……..……..……..**Y** **N**
Local Anesthetics……..……..**Y** **N**
Penicillin……..……**Y** **N**
Other Antibiotics……..……**Y** **N**
Codeine……..……**Y** **N**
Other Pain Medication……..……**Y** **N**
Aspirin……..……**Y** **N**
Barbiturates or Sedatives……..……**Y** **N**
Other Medicines……..……..……**Y** **N**

If so, which medicines?……..……..……..……
……..……..……
……..……

Kidney infections……..……..**Y** **N**
Kidney surgery……..……..**Y** **N**
Hepatitis……..……..**Y** **N**
HIV Positive……..……..**Y** **N**
Veneral Disease (within the last 10 yrs)……..**Y** **N**
Tuberculosis……..……..**Y** **N**
Frequent Fainting……..……..**Y** **N**
Liver Disease……..……**Y** **N**
Arthritis……..……..**Y** **N**
Ulcers……..……..……**Y** **N**
Glaucoma……..……..**Y** **N**
Cancer……..……..…… **Y** **N**
Radiation Therapy (for Cancer)……..…… **Y** **N**
Epilepsy……..……..**Y** **N**
Do you smoke……..……..**Y** **N**
Do you use any other form of tobacco……..…**Y** **N**

Women only, are you pregnant?.....**Y** **N**
If so, when are you due?……

Are you currently taking any of the following drugs or medications?

Antibiotics……..……..**Y** **N**
Blood Thinners……..……..**Y** **N**
Steroids or Cortisone……..……..……**Y** **N**
High Blood Pressure Medication……..……**Y** **N**
Tranquilizers……..……..**Y** **N**
Aspirin……..……..……**Y** **N**

Please list all medications you are currently taking
……..……
……..……
……..……
……..……

Dental History

Former dentist……..... Last dental visit..... Date of last full mouth x-rays.....

Do you have dentures or partial dentures?.....**Y** **N**
Do you have bridges or crowns?.....**Y** **N**
Have you ever worn braces?.....**Y** **N**
Have you ever had gum surgery?.....**Y** **N**

Have you ever had difficulty with any dental work or extractions?.....**Y** **N**
Have you ever had dental implant surgery?.....**Y** **N**

Do you need to be pre-medicated (take antibiotics) before your dental visits?.....**Y** **N**

Patient's Signature: ……..…. **Doctor's Signature:** ……