PLEASE PRINT

Date:

(Mr.) ☐ (Mrs.) ☐ (Miss) ☐ (Ms.) ☐ (Last) (First)

Address (No.) (City) (State) (Zip Code)

Date of Birth Present Age M ☐ F ☐

Home Phone (Area Code) (Number) Cell Phone (Area Code) (Number)

Occupation Patient's SS#

Employed by: (Name)

(No.) (City) (State) (Zip Code)

Name of (Spouse) or (Parent) (Spouse) or (Parent, if Minor)

Who referred you to our office

Dentist's Name (Last) (First)

Dentist's Address (No.) (City) (State) (Zip Code)

Name of Pharmacy

MEDICAL HISTORY

Please complete the following questions in order that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

	Yes	No
1. Has there been any change in your general health within the past year?	☐	☐
Please specify		
2. Are you under the care of a physician for a current problem?	☐	☐
Nature of treatment		
3. Have you been hospitalized within the past five years?	☐	☐
Reason		
4. Are you taking any medications or drugs?	☐	☐
Please specify		

5. Have you received therapy for alcoholism or drug addiction within the past five years? ☐ ☐

6. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma? ☐ ☐

Reason

7. Have you ever required a blood transfusion? ☐ ☐

Please explain

8. Have you ever had surgery and/or radiation treatment? ☐ ☐

9. Have you ever been tested for HIV infections (AIDS)? ☐ ☐

Result of test: Date ☐ Positive ☐ Negative

10. Please specify any ALLERGIC OR ADVERSE REACTIONS you have ever had to anesthetics, latex, antibiotics, or other medications

11. Date of last physical exam.

12. Do you have or have you had any of the following (please check):

- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Prolapsed valve (MVP)
- ☐ Joint prosthesis (hip, knee, etc)
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Cardiovascular disease, heart attack, stroke, by-pass
- ☐ Prosthetic heart valve
- ☐ Blood disorder (eg. anemia)
- ☐ Venereal disease
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Sinus trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach ulcers or irritable bowel syndrome
- ☐ Colitis
- ☐ Hepatitis, jaundice, liver disease
- ☐ Kidney problems
- ☐ Psychiatric treatment
- ☐ Epilepsy, fainting spells or seizures
- ☐ Cancer
- ☐ Temporomandibular joint problems (TMJ)
- ☐ Arthritis

13. Do you have any disease, condition or problem not listed above? ☐ ☐

Please specify

14. Are you required to take antibiotics prior to dental treatment? ☐ ☐

Women:

15. Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ ☐

16. Do you take birth control pills? ☐ ☐

If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.

All of the above information is true to the best of my knowledge.

Date

Signature of Patient

All signatures must be made by Parent or Guardian if patient is under the age of 18

Submit