MEDICAL HISTORY

Patient Name_____ DOB_____

Name of Physician_____

Date of recent examination by physician _____ Purpose_____

DO YOU HAVE OR HAVE YOU EVER HAD:

	Yes	No
1. Hospitalization for illness or injury_____	__	__
2. An allergic reaction to		
_ aspiring, ibuprofen, acetaminophen, codeine		
_ penicillin		
_ erythromycin		
_ tetracycline		
_ sulfa		
_ local anesthetic		
_ fluoride		
_ latex		
_ other_____		
3. Heart problems or stent within last 6 months_____	__	__
4. History of infective endocarditis_____	__	__
5. Artificial heart valve, repaired heart defect_____	__	__
6. Pacemaker or implanted defibrillator_____	__	__
7. Joint replacement_____	__	__
8. Rheumatic or scarlet fever_____	__	__
9. High or low blood pressure_____	__	__
10. A stroke and taking blood thinner_____	__	__
11. Anemia_____	__	__
12. Emphysema or shortness of breath_____	__	__
13. Kidney disease_____	__	__
14. Liver disease_____	__	__
15. Thyroid, parathyroid deficiency_____	__	__
16. High cholesterol taking statin drugs_____	__	__
17. Diabetes_____	__	__
18. Osteoporosis taking bisphosphonates _____	__	__

	Yes	No
19. Arthritis_____	__	__
20. Contacts_____	__	__
21. Head or neck injury_____	__	__
22. Epilepsy, seizures_____	__	__
23. Cold sores_____	__	__
24. Any lumps/swelling in mouth	__	__
25. Hepatitis (type____)_____	__	__
26. HIV/AIDS_____	__	__
27. Radiation Therapy_____	__	__
28. Chemotherapy_____	__	__
29. Immunosuppressive meds___	__	__
30. Antidepressant medication___	__	__
31. Psychiatric treatment_____	__	__
Are you:		
32. being treated for any illness__	__	__
33. Aware of change in health in last 24 hours (chills, fever,diarrhea)	__	__
34. Experiencing frequent headaches	__	__
35. Smoke or use smokeless tobacco	__	__
36. FEMALE: Taking birth control	__	__
37. FEMALE: Pregnant _____	__	__

Describe any current medical treatment, impending surgery, or other treatment that may affect your dental treatment

_____

_____

List all medications :

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____