



MEDICAL HISTORY

1. When was your last physical check-up? _____
2. Have you been hospitalized or had a serious illness in the last five years? ----- YES NO
3. Are you currently being treated by a physician for an illness or medical condition? ----- YES NO
4. Do you need to take antibiotics before dental visits? ----- YES NO
5. Are you allergic or sensitive to drugs or local anesthetics? ----- YES NO

6. Indicate which of the following you have had or currently have. Please circle **YES** or **NO**.

Diabetes -----	YES	NO	Smoking -----	YES	NO	Osteoporosis -----	YES	NO
Heart Attack -----	YES	NO	Alcohol use -----	YES	NO	Shortness of breath -----	YES	NO
Heart Failure -----	YES	NO	Tobacco use -----	YES	NO	Dizziness, nausea-----	YES	NO
Heart Surgery -----	YES	NO	Drug Addiction -----	YES	NO	Fainting -----	YES	NO
High Blood Pressure -----	YES	NO	Bleeding problems -----	YES	NO	Headaches, migraines -----	YES	NO
Stroke -----	YES	NO	Sinus problems -----	YES	NO	Anemia, blood disease -----	YES	NO
Heart Murmur -----	YES	NO	Vomiting -----	YES	NO	Glaucoma, cataract -----	YES	NO
Hepatitis -----	YES	NO	Stomach problems, ulcers ---	YES	NO	Eye Disease -----	YES	NO
Mitral Valve Prolapse -----	YES	NO	Diarrhea -----	YES	NO	Head Injuries -----	YES	NO
Prosthetic Valve -----	YES	NO	Constipation -----	YES	NO	Body Injuries -----	YES	NO
Joint Replacement -----	YES	NO	Rheumatic fever -----	YES	NO	Jaundice-----	YES	NO
Hip Replacement -----	YES	NO	Rheumatism -----	YES	NO	Liver Disease -----	YES	NO
Pacemaker -----	YES	NO	Arthritis -----	YES	NO	Bladder Disease -----	YES	NO
Seizure, epilepsy -----	YES	NO	Asthma -----	YES	NO	Kidney Disease -----	YES	NO
Cancer, tumor -----	YES	NO	Tuberculosis -----	YES	NO	Thyroid Disease -----	YES	NO
Radiation therapy -----	YES	NO	Emphysema -----	YES	NO	Venereal Disease -----	YES	NO
Chemotherapy -----	YES	NO	Lung disease -----	YES	NO	Mental Illness -----	YES	NO
AIDS -----	YES	NO	Allergies to food -----	YES	NO	Nervousness -----	YES	NO
HIV Positive -----	YES	NO	Allergy to latex -----	YES	NO	Recent weight loss or gain --	YES	NO

7. Are you currently taking or have taken:
 - recreational drugs? ----- YES NO
 - weight loss medication, herbal supplements? ----- YES NO
 - Fen-phen, Redux, Pondimin, or other fenfluramine or dexfenfluramine related drugs? ----- YES NO
 - Fosamax, Zometa, Aredia, Actonel, Didronel, Skelid, Boniva, Bonefos, or Osteo related drugs? ----- YES NO
 - Do you take aspirin daily? ----- YES NO

8. Women only.
 - Are you pregnant? ----- YES NO
 - Are you nursing? ----- YES NO

9. Do you have or have you had any diseases or medical problems NOT listed on this form? ----- YES NO
10. Are you currently taking prescribed medications, or over-the-counter medicines? ----- YES NO

PLEASE LIST ANY MEDICATIONS, AND EXPLAIN "YES" ANSWERS IF NEEDED

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health.

Patient Name: _____ **Patient Signature / Parent if minor:** _____ **Date:** _____

DOCTOR'S NOTES BP _____ pulse _____

Reviewed by Dr. _____

Date: _____