

Medical History

NAME _____

DATE _____

In order to give you complete dental health care, please answer the following questions. Your reply will be kept in strict confidence.

General Health (please check): Excellent Good Fair Poor

Name of Physician : _____

Last complete physical? _____ Are you being treated by a physician now? Yes No

Have you recently been hospitalized? Yes No

Are you taking any medication now? Yes No List medication _____

Check "yes" or "no" for all of the following conditions that you might have had or might have at present:

Infective Endocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease or Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina Pectoris	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS / HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes Virus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immuno Suppressed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A (infectious)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis (TB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B (serum)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer / Chemo	<input type="checkbox"/> Yes <input type="checkbox"/> No	GERD	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever taken Phen-Fen / Redux? Yes No

Are you allergic to Penicillin Codeine Local Anesthetic Latex Other medications _____

Are you subject to prolonged bleeding? Yes No Are you subject to fainting spells? Yes No

Women: Are you pregnant? Yes No Expected due date: _____

Do you have any sensitivity to metals? Yes No

Do you use tobacco? Yes No

OFFICE USE :

Medical History Updates