MEDICAL HISTORY

It is important to tell all dental personnel involved in your treatment about the general state of your health. This information is confidential.

Patients Name: _____ **DATE OF BIRTH** _____

Patients Home/Cell Phone Number: _____

1. Name and address of physician _____
2. When was your last physical examination? _____
3. Are you now under the care of a physician? Yes __ No __ If yes, for what reason? _____

4. Have you been told you should be taking an antibiotic (premedication) prior to dental visits? ..... Yes No
5. Are you taking a blood thinner (Coumadin)? ..... Yes No
6. Are you presently taking any medications/drugs/pills? ..... Yes No
   Please List: _____
7. Are you presently taking a medication for soft bone (osteoporosis) (Fosamax)? Yes __ No __
8. (Women) Are you pregnant? Yes __ No __ If yes, how long? _____
9. Are you allergic to: Penicillin __ Codeine __ Local Anesthetic __ Latex __ None __ Other __ _____
   Pharmacy Name: _____ Pharmacy Phone Number: _____
10. Do you have, or have you ever had:

Heart Trouble	Yes	No	Arthritis	Yes	No
Heart Murmur	Yes	No	Excessive or Prolonged Bleeding	Yes	No
Heart Surgery	Yes	No	Fainting Spells	Yes	No
Heart Pacemaker	Yes	No	Jaundice	Yes	No
Rheumatic Fever	Yes	No	Hepatitis - Type:	Yes	No
High or Low Blood Pressure	Yes	No	Asthma or Hay Fever	Yes	No
Ulcers	Yes	No	Sinus Trouble	Yes	No
Tuberculosis or Lung Disease	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	Chemotherapy/Radiation	Yes	No
Epilepsy or Seizure Disorders	Yes	No	Stroke	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No
Thyroid Problem	Yes	No	Psychiatric Care	Yes	No
Chemical Dependency	Yes	No	Venereal Disease	Yes	No
Smoke/Chew or use any form Tobacco	Yes	No	HIV Positive/AIDS/ARC	Yes	No
			Prosthetic Implant/Joint Replacement	Yes	No

11. Have you had any other serious illnesses, hospitalization or accident? Yes No
    If yes, please explain _____

Patient's/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

OFFICE USE ONLY

DATE _____

1. Any changes in medical history?	Y or N
2. Are you under a doctor's care?	Y or N
3. Any changes in medications or dosages?	Y or N
4. Any new allergies?	Y or N
5. Are you pregnant or nursing?	Y or N

Notes: _____

Signature: _____

DATE _____

1. Any changes in medical history?	Y or N
2. Are you under a doctor's care?	Y or N
3. Any changes in medications or dosages?	Y or N
4. Any new allergies?	Y or N
5. Are you pregnant or nursing?	Y or N

Notes: _____

Signature: _____