

Medical History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you or have you ever been treated for:

	Yes	No		Yes	No		Yes	No
Any Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Do you Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Allergic Reactions:		
Congenital Heart Disease *	<input type="checkbox"/>	<input type="checkbox"/>	Lung / Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse *	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Defect*	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	<input type="checkbox"/>
Epsteins Disease *	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Replacement *	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever *	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint (Hip / Knee) *	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Healing	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other Medication (Please List)		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Adrenal / Pituitary Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Bypass	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disorder / Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Cancer / Tumor	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder / Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Other Growths	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy / Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Any Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Trouble / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Nervous or Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Sickle Cell Trait	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>			
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>			
Are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>			

Have you ever had a major operation or been hospitalized? Yes No Explain: _____

Have you ever had a serious injury to your head or neck? Yes No Explain: _____

* Do you need to take antibiotic premedication prior to dental appointments? Yes No Don't know
Name of antibiotic: _____

Do you have any current health problems not noted above? Yes No What? _____

Are you currently being treated by a physician? Yes No Why? _____

Physician's name, address, and phone: _____

Are you presently taking any medications? Yes No Please list:

Name: _____	For: _____	Name: _____	For: _____
Name: _____	For: _____	Name: _____	For: _____
Name: _____	For: _____	Name: _____	For: _____

To the best of knowledge, the foregoing questions have been accurately answered.

Signature _____ Date _____

Print name _____ If other than patient, indicate relationship _____