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: (Please Circle Choice)

Any Heart Problems	Yes	No
Congenital Heart Disease *	Yes	No
Mitral Valve Prolapse *	Yes	No
Heart Valve Defect*	Yes	No
Epsteins Disease *	Yes	No
Heart Valve Replacement *	Yes	No
Rheumatic Fever *	Yes	No
Artificial Joint (Hip / Knee) *	Yes	No
Angina	Yes	No
Stroke	Yes	No
Heart Attack	Yes	No
Bypass	Yes	No
Pacemaker	Yes	No
High Blood Pressure	Yes	No
Low Blood Pressure	Yes	No
Any Bleeding Disorders	Yes	No
Anemia	Yes	No
Hemophilia	Yes	No
Sickle Cell Trait	Yes	No
Blood Transfusions	Yes	No
Are you Pregnant?	Yes	No
Do you Smoke?	Yes	No
Lung / Breathing problems	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Emphysema	Yes	No
Tuberculosis	Yes	No
Sinus Trouble	Yes	No
Difficulty Healing	Yes	No
Diabetes	Yes	No
Thyroid Problems	Yes	No
Adrenal / Pituitary Disorders	Yes	No

Liver Disorder / Dysfunction	Yes	No
Hepatitis / Jaundice	Yes	No
Kidney Disorder / Dysfunction	Yes	No
Renal Dialysis	Yes	No
Stomach Trouble / Ulcers	Yes	No
Nervous or Mental Disorder	Yes	No
Epilepsy or Seizures	Yes	No
Alcoholism	Yes	No
Drug Abuse	Yes	No
Fainting Spells	Yes	No
Cancer / Tumor	Yes	No
Other Growths	Yes	No
Chemotherapy / Radiation	Yes	No
Therapy	Yes	No
Sexually Transmitted Diseases	Yes	No
HIV / AIDS	Yes	No
Allergic Reactions:	Yes	No
Penicillin	Yes	No
Erythromycin	Yes	No
Sulfa	Yes	No
Codeine	Yes	No
Aspirin	Yes	No
Latex	Yes	No
Local Anesthetic	Yes	No
Other Medication Allergies:	Yes	No

(Please List)

_____

_____

_____

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: _____

Current Medications: (Please List)

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

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

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

Print Name _____ If other than patient, indicate relationship_____

Signature _____ Date _____