

Medical History

Patient Name _____ Date ___/___/___

The thoroughness of this medical history is designed for your safety. Your complete answers will assist us in treating you with every consideration for your health special needs. This information is confidential.

Name of personal physician _____ Phone # _____

How do you assess your current health: Excellent Good Fair Poor

Yes No Are you currently under the care of a physician?

If yes, please explain: _____

Yes No Have you been hospitalized or had any serious medical problems within the past 5 years? _____

If yes, please explain: _____

Yes No Do you have heart trouble or any form of cardiovascular disease?

Angina (chest pains) Frequency _____ Rheumatic Fever (date) _____

Heart attack (date) _____ Heart murmur/mitral valve prolapse

Heart surgery (date) _____ High blood pressure

Pacemaker Stroke (date)

Bypass Other _____

Prosthetic heart valve

Have you ever had or been treated for any of the following diseases or medical conditions?

Yes No

- Hepatitis/Jaundice
- Epilepsy/Seizures/Fainting
- Cancer/Chemotherapy
- Psychiatric problems
- Tuberculosis
- AIDS/HIV
- Drugs/Alcohol abuse
- Ulcers

Yes No

- Abnormal bleeding
- Kidney problems
- Diabetes
- Asthma or lung disease
- Hip or joint replacement
- Anemia
- Arthritis
- Glaucoma

Yes No Have you ever been treated for any illnesses not listed above? If yes, please explain:

Are you allergic to any of the following medications?

Yes No

- Penicillin
- Erythromycin
- Codeine

Yes No

- Dental Anesthetic
- Latex
- Aspirin

Yes No Are you allergic to any other pain medications or antibiotics? If yes, please list:

Yes No Have you ever been advised to take antibiotics before dental treatment?

Yes No Have you ever taken the diet pill phen fen?

Yes No Are you currently taking prescription medications? (If yes, please list below)

Name of Medication

Purpose

Yes No Do you use "Recreational" drugs

"Recreational" drugs such as cocaine, marijuana, stimulants or depressants (prescription and over-the-counter) may have dangerous interactions with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor.

Yes No Women: Are you pregnant? (expected delivery date _____)

Yes No Women: Are you taking birth control pills?

(Certain antibiotics may adversely interact with oral contraceptives.)

NOTES:

Patient's B.P. is: _____ Date _____

Med. Hx. Rev. (int'l): _____ Date _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor. If deemed advisable, I grant permission for my physician to be contacted for details and advise. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the doctor and office staff. I also give permission for the doctor or his staff to use any photos he may take to be used for lecturing or educational purposes. I understand that I am financially responsible for all treatment rendered, regardless of insurance involvement.

Signature of Patient or Guardian (if patient is a minor)

Date