MEDICAL HISTORY

Please complete the following questions in order that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

	Yes	No
1. Has there been any change in your general health within the past year?.....	☐	☐
Please specify_____		
2. Are you under the care of a physician for a current problem?.....	☐	☐
Reason_____PhysicianName:_____		
Physician Phone Number_____		
3. Have you been hospitalized within the past five years?.....	☐	☐
Reason_____		
4. Are you taking any drugs or medication at this time?.....	☐	☐
Please specify_____		
_____		
5. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to anesthetics, antibiotics or other medications?.....	☐	☐
Please specify_____		
6. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?.....	☐	☐
7. Do you take aspirin on a regular basis?.....	☐	☐
8. Does your Medical Doctor require you to take antibiotics prior to all dental treatment?.....	☐	☐

9. Do you have or have you had any of the following (please check):

YES	NO		YES	NO		YES	NO	
☐	☐	High blood pressure	☐	☐	Sinus Trouble	☐	☐	Seizures
☐	☐	Heart murmur or prolapsed valve (MVP)	☐	☐	Diabetes	☐	☐	Epilepsy
☐	☐	Joint prosthesis (hip, knee, etc.)	☐	☐	Stomach ulcers	☐	☐	Latex allergies
☐	☐	Rheumatic fever or rheumatic heart disease	☐	☐	Colitis	☐	☐	Phen- Fen or a Diet drug
☐	☐	Congenital heart disease	☐	☐	Kidney problems	☐	☐	Bisphosphinates/ Bone density medication
☐	☐	Cardiovascular disease	☐	☐	Hepatitis A			
☐	☐	Prosthetic heart valve	☐	☐	Hepatitis B			
☐	☐	Blood disorder (e.g., anemia)	☐	☐	Hepatitis C			
☐	☐	Venereal disease	☐	☐	Blood transfusion			
☐	☐	Asthma-If Yes how is it controlled?_____	☐	☐	Liver disease			
☐	☐	Emphysema	☐	☐	HIV/AIDS			
☐	☐	Temporomandibular joint problems (TMJ)	☐	☐	Psychiatric treatment			
☐	☐	Tuberculosis (TB)	☐	☐	Fainting spells			

10. Do you have any disease, condition, or problem not listed above?.....	☐	☐
Please specify_____		
FOR WOMEN:		
11. Are you pregnant?.....	☐	☐
Due date:_____		
12. Are you nursing?.....	☐	☐
13. Do you take birth control pills?.....	☐	☐
If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.		

All of the above information is true to the best of my knowledge.

_____ _____

Date Signature of Patient

_____ _____

Date Signature of Patient