Medical History

Please complete the following questions so 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. Are you required to take a **premed** prior to dental treatment?	☐	☐
2. Has there been any changes in your general health within the past year?	☐	☐
If so, please specify: _____		
3. Are you under the care of a physician for a current problem?	☐	☐
Reason: _____		
4. Have you been hospitalized within the past five years?	☐	☐
Reason: _____		
5. Have you received therapy for alcoholism or drug addiction during the past five years?	☐	☐
6. Have you ever had abdominal bleeding with previous extractions, surgery, or trauma?	☐	☐
7. Have you ever required a blood transfusion?	☐	☐
Reason: _____		
8. Have you ever had surgery and/or radiation for a tumor, growth or other condition?	☐	☐
If so, please specify: _____		
9. Date of last physical exam: _____		
10. Are you currently taking any **medications or drugs**?	☐	☐

Please List:

11. Do you have or have you had any of the following

- ☐ High blood pressure
- ☐ Heart murmur or prolapsed valve (MVP)
- ☐ Joint prosthesis (hip, knee, etc.)
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Do you have a pacemaker or cochlear implant?
- ☐ Cardiovascular disease: heart attack, stroke, by-pass
- ☐ Are you taking any blood thinners?
- ☐ Prosthetic heart valve
- ☐ Blood disorder (e.g., anemia)
- ☐ STD
- ☐ HIV/AIDS
- ☐ Asthma
- ☐ Temporomandibular joint problems (TMJ)
- ☐ Tobacco use
- ☐ Sinus trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach ulcers, colitis
- ☐ Hepatitis, jaundice, liver disease
- ☐ Kidney problems
- ☐ Psychiatric treatment
- ☐ Fainting spells or seizures
- ☐ Epilepsy
- ☐ Cancer
- ☐ Are you currently, or have you taken medicines for Osteoporosis?
- ☐ Delay in healing

12. Do you have any disease, condition, or problem not listed above?	☐	☐
If so, please specify: _____		
13. Any **ALLERGIC OR ADVERSE REACTIONS** to **LATEX**, anesthetics, antibiotics, or other medications?	☐	☐

Please List:

Women:

14. Are you pregnant?	☐	☐
15. Are you nursing?	☐	☐
16. Do you take birth control pills?	☐	☐

If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.

Preferred Pharmacy: _____

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

Signature of Patient: _____ Date: _____

*All signatures must be by a parent or guardian if patient is under the age of 18.

Medications List (additional Space):

Name	Reason for Taking	Dosage (if available)

Allergy List (additional Space):
