Patient Medical History (Confidential)

Your oral health is an integral part of your complete fitness. The medical information we request is to help us give you the best dental care possible for your continued good health.

Name:	Today's Date:	
Birthdate:	Height:	Weight:
Physician:	Specialist:	

Are you currently taking any medications? Yes No

If Yes, what: This medication is to treat:

Have you ever had a serious illness or operation? Yes No

If Yes, please explain:

Please identify any of the following that pertain to you.

Abnormal Heart Condition .... Yes No
Explain:
AIDS/HIV .... Yes No
Angina .... Yes No
Anemia .... Yes No
Any Bleeding Disorders .... Yes No
Artificial Joints .... Yes No
Where?
Asthma .... Yes No
Allergies .... Yes No
Hay Fever .... Yes No
Frequent Sore Throats .... Yes No
Bronchitis .... Yes No
Bypass .... Yes No
Cancer/Tumor.............................. Yes No
Type:
Diabetes .... Yes No
Smoke .... Yes No
Drugs or Alcohol dependency.............................. Yes No
Emphysema .... Yes No
Epilepsy or Seizures .... Yes No
Fainting or Dizzy Spells .... Yes No
Frequent "Cold Sores" / Fever Blisters .... Yes No
Frequent Nose Bleeds .... Yes No
Healing Difficulty .... Yes No
Heart Attack .... Yes No
Heart Valve Defect .... Yes No
When:

Heart Valve Prolapse .... Yes No
Heart Murmur .... Yes No
Hemophilia .... Yes No
Hepatitis/Jaundice .... Yes No
Type: A B C
Blood Pressure .... High Low
Kidney or Liver Problems .... Yes No
Mental Disorder .... Yes No
Mitral Valve Prolapse .... Yes No
Nervous Problems or
Nervous Breakdown .... Yes No
Pacemaker .... Yes No
Premedication Required .... Yes No
Problem with:
Local or General Anesthesia .... Yes No
Rheumatic Fever or Rheumatic
Heart Disease .... Yes No
Sickle Cell Trait .... Yes No
Sinusitis .... Yes No
Stroke .... Yes No
Thyroid Condition .... Yes No
Tuberculosis .... Yes No
Radiation Treatment .... Yes No
Shortness of Breath or Swollen Ankles .... Yes No
Stomach or Intestinal Disease .... Yes No
Sexually Transmitted Disease .... Yes No

Are you allergic to:

Aspirin .... Yes No
Codeine .... Yes No
Erythromycin .... Yes No
Penicillin .... Yes No
Novocain .... Yes No
Sulfa Drugs .... Yes No
Latex .... Yes No
Antibiotics .... Yes No
Which ones:
Other .... Yes No
Specify:

Women:

Are you pregnant? .... Yes No
If yes, due date:
Are you taking birth control pills? .... Yes No

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Signature Date