Medical History

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

Do you require pre-medication prior to any dental treatment (due to e.g. joint replacement)?

☐ Yes ☐ No	Reason:	Type:	Dosage:

Have you been hospitalized within the past FIVE years?

☐ Yes ☐ No	Please specify reason and year:

Have you ever had any ALLERGIC or ADVERSE REACTION to dental anesthetics, antibiotics, other medications, or household cleaners?

Name of medicine or irritant	Reaction	Name of medicine or irritant	Reaction

Current Medications (Prescription, Over-The-Counter and Herbal)

Medication Name	Reason for medication	Medication Name	Reason for medication

Check 'yes' or 'no' to indicate whether or not you have had or now have the following conditions or treatments:

Yes	No	
		High blood pressure
		Stomach ulcers, Colitis
		Heart murmur or prolapsed valve (MVP)
		Tuberculosis
		Joint prostheses (hip, knee, etc.)
		Hepatitis A, B, or C
		Rheumatic fever or rheumatic heart disease
		Jaundice or Liver disease
		Congenital heart disease
		Kidney problems
		Abnormal bleeding with surgery, or extractions
		Surgery, radiation for tumor or other
		Cardiovascular disease, heart attack, stroke, bypass
		Fainting spells or seizures
		Prosthetic heart valve
		Epilepsy
		Dental Anxiety

Yes	No	
		Blood disorder-Type:
		Cholesterol problem
		Diabetes-Type:
		Trauma
		Latex allergy
		Venereal disease-Type:
		HIV/AIDS-Date tested: (+/-)
		Asthma
		Cancer-Type:
		Blood transfusion-Date:
		Temporomandibular joint (TMJ)
		Sinus trouble
		Thyroid problems: overactive or underactive
		Use of tobacco products-How often?
		Psychiatric treatment-Reason:
		Alcoholism or drug addiction
		Date of last physical exam:

Please list any additional disease, condition or problem not listed above:

_____

Women:

Are you pregnant or planning a pregnancy?	☐ Yes ☐ No	If yes, due date:
Are you taking birth control?	☐ Yes ☐ No	Type:
Are you a nursing mother?	☐ Yes ☐ No	

_____ _____ _____

Name of Patient (Please Print) Signature of Patient or Legal Guardian Date