

MEDICAL HISTORY

PATIENT NAME _____ DATE _____

Are you under the care of a physician? YES _____ NO _____

EXPLAIN _____

NAME OF PHYSICIAN _____ PHONE _____

HAVE YOU EVER BEEN HOSPITALIZED? YES _____ NO _____ EXPLAIN _____

ARE YOU TAKING ANY DRUG/MEDICATION NOW? LIST _____

- | | | |
|-----------------------------|----------------------|----------------------|
| _____ Heart Medication | _____ Insulin | _____ Blood Pressure |
| _____ Corticosteroids | _____ Thyroid | _____ Aspirin |
| _____ Narcotics | _____ Anticoagulants | _____ Antibiotics |
| _____ Methadone | (blood thinners) | |
| _____ Other (explain) _____ | | |

FEMALES ONLY: Do you take oral contraceptives? YES _____ NO _____
 Are you pregnant? YES _____ NO _____ What month? _____

Have you ever had abnormal bleeding associated with previous extractions, surgery or accidents? YES _____ NO _____ Explain _____

Do you have AIDS/ARC/HIV+ YES _____ NO _____

Have you had radiation treatment/chemotherapy? _____

Do you have a total hip or knee or other joint prostheses? YES _____ NO _____

Do you have a heart murmur or mitral valve prolapse? YES _____ NO _____

Are you allergic or have you reacted adversely to:

- | | | |
|------------------------|----------------------------------|--------------------|
| _____ Local anesthesia | _____ Foods | _____ Penicillin |
| _____ Aspirin | _____ Pain Medication | _____ Erythromycin |
| _____ Sulfa drugs | _____ Sedatives or Tranquilizers | _____ Latex Gloves |
| _____ Other _____ | | |

Do you have a pacemaker, prosthesis, artificial heart valve? YES _____ NO _____

Do you have or have you had any of the following conditions:

- | | | |
|--------------------------------|-----------------------|------------------------|
| _____ rheumatic fever | _____ chest pain | _____ sickle cell |
| _____ rheumatic heart disease | _____ ulcers | _____ venereal disease |
| _____ congenital heart disease | _____ sinus condition | _____ arthritis |
| _____ heart attack | _____ asthma | _____ glaucoma |
| _____ heart murmur | _____ bronchitis | _____ anemia |
| _____ shortness of breath | _____ emphysema | _____ hepatitis |
| _____ ankle swelling | _____ tuberculosis | _____ liver disease |
| _____ high blood pressure | _____ lung disease | _____ jaundice |
| _____ fainting spells | _____ thyroid disease | _____ cirrhosis |
| _____ epilepsy, seizures | _____ diabetes | _____ stroke |
| _____ itching/rash | _____ paralysis | _____ kidney disease |
| _____ hearing loss | _____ depression | _____ porphyria |
| _____ nervous breakdown | _____ other (explain) | _____ |

DATE _____

Dentist signature _____

Signature of Patient/Guardian _____

DATE _____

Dentist signature _____

Signature of Patient/Guardian _____

DATE _____

Dentist signature _____

Signature of Patient/Guardian _____