

**MEDICAL HISTORY**

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:

ANY HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU SMOKE	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC REACTION (HIVES / SWELLING) TO:		<input type="checkbox"/>	<input type="checkbox"/>
HEART MURMUR*	<input type="checkbox"/>	<input type="checkbox"/>	LUNG/BREATHING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	PENICILLIN		<input type="checkbox"/>	<input type="checkbox"/>
MITRAL VALVE PROLAPSE*	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	ERYTHROMYCIN		<input type="checkbox"/>	<input type="checkbox"/>
HEART VALVE DEFECT*	<input type="checkbox"/>	<input type="checkbox"/>	BRONCHITIS	<input type="checkbox"/>	<input type="checkbox"/>	SULFA		<input type="checkbox"/>	<input type="checkbox"/>
HEART VALVE REPLACEMENT*	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>	CODEINE		<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER*	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	ASPIRIN		<input type="checkbox"/>	<input type="checkbox"/>
ARTIFICIAL JOINT (HIP / KNEE)*	<input type="checkbox"/>	<input type="checkbox"/>	SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	LATEX		<input type="checkbox"/>	<input type="checkbox"/>
ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	DIFFICULTY IN HEALING	<input type="checkbox"/>	<input type="checkbox"/>	LOCAL ANESTHETIC (NOVOCAIN)		<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	OTHER MEDICATIONS OR SUBSTANCES? Please list:		<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____			
BYPASS	<input type="checkbox"/>	<input type="checkbox"/>	ADRENAL/PITUITARY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____			
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	LIVER PROBLEMS / DYSFUNCTION	<input type="checkbox"/>	<input type="checkbox"/>				
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS / JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>	CANCER / TUMOR		<input type="checkbox"/>	<input type="checkbox"/>
LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY PROBLEMS / DYSFUNCTION	<input type="checkbox"/>	<input type="checkbox"/>	OTHER GROWTHS		<input type="checkbox"/>	<input type="checkbox"/>
ANY BLEEDING DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH TROUBLE / ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY / RADIATION THERAPY		<input type="checkbox"/>	<input type="checkbox"/>
ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUS OR MENTAL DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASES		<input type="checkbox"/>	<input type="checkbox"/>
HEMOPHILIA	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	OTHER INFECTIOUS DISEASES		<input type="checkbox"/>	<input type="checkbox"/>
SICKLE CELL TRAIT	<input type="checkbox"/>	<input type="checkbox"/>	ALCOHOLISM	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS		<input type="checkbox"/>	<input type="checkbox"/>
BLOOD TRANSFUSIONS	<input type="checkbox"/>	<input type="checkbox"/>	DRUG ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT?		<input type="checkbox"/>	<input type="checkbox"/>

\*DO YOU NEED TO TAKE ANTIBIOTIC PREMEDICATION PRIOR TO DENTAL APPOINTMENTS?  YES  NO  DON'T KNOW NAME OF ANTIBIOTIC: \_\_\_\_\_

DO YOU HAVE ANY CURRENT HEALTH PROBLEMS NOT NOTED ABOVE?  YES  NO WHAT? \_\_\_\_\_

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN?  YES  NO WHY? \_\_\_\_\_

PHYSICIAN'S NAME, ADDRESS AND PHONE: \_\_\_\_\_

ARE YOU PRESENTLY TAKING ANY MEDICATIONS, PILLS, OR TONICS?  YES  NO LIST: \_\_\_\_\_ FOR: \_\_\_\_\_

(I.E., BLOOD PRESSURE, BIRTH CONTROL, STEROIDS, HORMONES) \_\_\_\_\_ FOR: \_\_\_\_\_

\_\_\_\_\_ FOR: \_\_\_\_\_

IS THERE ANY CONDITION OR PROBLEM RELATING TO YOUR MEDICAL HISTORY THAT HAS NOT BEEN MENTIONED?  YES  NO EXPLAIN: \_\_\_\_\_

DATE PATIENT / GUARDIAN SIGNATURE DOCTOR / HYGIENIST SIGNATURE

**YEARLY REVIEW OF PATIENT MEDICAL HISTORY**

NO CHANGE	CHANGE	LIST:			
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____

MEDICAL ALERT RECOMMENDED:	YES	NO	DATE:	INTERVIEWER NOTES
1) _____				
2) _____				
3) _____				
PREMEDICATION RECOMMENDED:	YES	NO		
Rx: _____				