MEDICAL HISTORY

NAME OF YOUR PHYSICIAN/CLINIC ____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE FOR A MEDICAL CONDITION? YES NO

If yes, please explain ____

DO YOU HAVE OR HAVE YOU EVER HAD:

YES NO HEART TROUBLE
YES NO HEART MURMER
YES NO ARTIFICIAL HEART VALVE
YES NO MITRAL VALVE PROLAPSE
YES NO HEART PACEMAKER
YES NO CHEST PAIN
YES NO RHEUMATIC FEVER
YES NO ARTIFICIAL JOINTS
YES NO HEMOPHILIA
YES NO BLEEDING DISORDERS
YES NO HIGH BLOOD PRESSURE
YES NO LOW BLOOD PRESSURE
YES NO DIABETES
YES NO STROKE
YES NO SHORTNESS OF BREATH
YES NO EMPHYSEMA
YES NO ASTHMA

YES NO SINUS TROUBLE
YES NO TUBERCULOSIS
YES NO HEPATITIS
YES NO AIDS/HIV POSITIVE
YES NO CANCER
YES NO CHEMOTHERAPY/RADIATION
YES NO NERVOUS DISORDERS
YES NO EPILEPSY/SEIZURES
YES NO FAINTING/DIZZINESS
YES NO HEADACHES/MIGRAINES
YES NO HEAD/FACIAL INJURIES
YES NO ARTHRITIS
YES NO ALLERGIES ___________________________________
____
YES NO ANY OTHER MEDICAL/HEALTH CONDITIONS?
____
____

DO YOU HAVE A MEDICAL CONDITION THAT REQUIRES YOU TAKE ANTIBIOTIC MEDICATION PRIOR TO DENTAL TREATMENT? YES NO

PLEASE LIST ANY MEDICATIONS (INCLUDING NONPRESCRIPTION) YOU ARE CURRENTLY TAKING AND WHY:

____

____

WOMEN: ARE YOU PREGNANT? ________ NURSING? ________ TAKING ORAL CONTRACEPTIVES? _________

HAVE YOU EVER HAD UNFAVORABLE REACTIONS TO ANY OF THE FOLLOWING:

ANESTHETICS/NOVOCAINE PENICILLIN/ANTIBIOTICS CODEINE ASPIRIN LATEX METAL

OTHER MEDICATIONS/MATERIALS ____

NAME AND PHONE NUMBER OF PERSON TO CONTACT IN CASE OF EMERGENCY:

____

The information that I have given today is correct to the best of my knowledge.
I understand it is my responsibility to inform this office of any changes in my medical status.

PATIENT SIGNATURE ____ DATE ______________________________