Medical History

Name:_________________________________ Date: ____________________

Do you have any allergies?

☐ None ☐ Allergies ☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Hay Fever
☐ Penicillin ☐ Sulfa ☐ Latex ☐ Other: ______________________

Indicate which of the following you have had or have at present.

Y N	Condition	Y N	Condition	Y N	Condition	Y N	Condition
Y N	Acid Reflux	Y N	Congenital Heart Def	Y N	HIV / AIDS	Y N	Sinus Problems
Y N	Annemia	Y N	Currently Pregnant	Y N	Kidney Disease	Y N	Sleep Apnea
Y N	Anxiety	Y N	Diabetes	Y N	Liver Disease	Y N	STI (Transmitted Inf)
Y N	Arthritis	Y N	Dizziness/Fainting	Y N	Low Blood Pressure	Y N	Stomach Problems
Y N	Artificial Bones	Y N	Drug Use	Y N	Nervous Disorders	Y N	Stroke
Y N	Artificial Joints	Y N	Excessive Bleeding	Y N	Osteoporosis	Y N	Thyroid Disorder
Y N	Artificial Valve	Y N	Frequent Headaches	Y N	Pacemaker	Y N	Tobacco Use
Y N	Asthma	Y N	Head Injuries	Y N	Psychiatric Disorder	Y N	Tuberculosis
Y N	Auto-immune Disorder	Y N	Heart Disease	Y N	Radiation Treatment	Y N	Tumors
Y N	Bacterial Endocarditis	Y N	Heart Murmur	Y N	Respiratory Issues	Y N	Ulcers
Y N	Blood Disease	Y N	Heart Surgery	Y N	Rheumatic Fever	Y N	Venereal Disease
Y N	Cancer	Y N	Hepatitis	Y N	Rheumatism	Y N	Other- explain below
Y N	Chest Pain	Y N	High Blood Pressure	Y N	Seizures		

Y N	Question	Y N	Question
Y N	Ever been hospitalized in the last 3 years	Y N	Presently being treated for any other illnesses
Y N	Taking medication for weight control (IE: fen-phen)	Y N	Females: taking birth control pills
Y N	Taking medication for osteoporosis (IE: Fosamax)		

If any condition selected above needs further clarification, please explain below: (We will review these verbally)

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Do you take antibiotic premedication for your dental visits? YES / NO If yes, please explain.

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List all medications, supplements, and/or vitamins taken within the last two years:

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How would you rate your overall general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of physician, their specialty, and date of most recent exam: ______________________________

Describe any current medical treatment, impending surgery, or other treatments that may possibly affect your dental treatment:

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☐ By checking this box, I acknowledge that the above information is correct, and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.