Medical History

1. Are you in good health? ❑ Yes ❑ No
2. Has there been a change in your general health within the last year? ❑ Yes ❑ No
3. Are you under the care of a physician? ❑ Yes ❑ No
4. If so, what condition is being treated? _____
5. Date of your last visit to your physician_____ Nature of Visit_____
6. Your Physician's Name:_____ Phone#:_____

   Your Cardiologist's Name:_____ Phone#:_____
7. Have you been hospitalized or had a serious operation or illness within the last five years? ❑ Yes ❑ No

   If so, for what?_____
8. Do you have, or have you had, any of the following diseases or problems? Please check:

❑ Heart Disease	❑ Rheumatic Fever	❑ Glaucoma	❑ Auto Immune Disease
❑ Heart Attack	❑ Artificial Joints	❑ Pain in Jaw Joints	❑ AIDS/HIV
❑ Heart Surgery	❑ High Blood Pressure	❑ Ulcers	❑ Lupus
❑ Heart Failure	❑ Emphysema	❑ Cold Sores	❑ Rheumatism
❑ Heart Murmur	❑ Diabetes	❑ Bleeding Disorders	❑ Cancer
❑ Mitral Valve Prolapse	❑ Kidney Trouble	❑ Anemia	❑ Radiation Treatment
❑ Chest Pain	❑ Thyroid Disease	❑ Sinus Trouble	❑ Sickle Cell Disease
❑ Heart Pacemaker	❑ Tuberculosis (TB)	❑ Asthma	❑ Fainting or Dizzy Spells
❑ Artificial Heart Valve	❑ Hepatitis A, B, or C	❑ Allergies	❑ Epilepsy or Seizures
❑ Stroke	❑ Liver Disease	❑ Arthritis	❑ Nervousness/Anxiety
			❑ Psychiatric Treatment

9. Do you have a disease, condition, or problem not listed above that you think I should know? ❑ Yes ❑ No

   If yes, please explain?_____
10. Have you ever been told to Pre-Medicate for a dental procedure? ❑ Yes ❑ No

    If so, why and with what antibiotic?_____
11. Are You taking any blood thinners ❑ Yes ❑ No
12. Are you taking any drugs or medicine? ❑ Yes ❑ No

    If so, what?_____

    _____
13. Are you allergic, or have reacted adversely, to any drugs or medicine? ❑ Yes ❑ No

    If so, which drugs?_____

❑ Aspirin	❑ Erythromycin	❑ Codeine	❑ Local Anesthetic	❑ Ephinephrine	
❑ Penicillin	❑ Tetracycline	❑ Sulfa	❑ Clindamycin	❑ Latex	❑ Amoxicillin

14. For Women Only: Are You pregnant? ❑ Yes ❑ No

    If so, what month?_____
15. Are you breast feeding? ❑ Yes ❑ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered the above information truthfully and to the best of my knowledge.

X_____ **Date:**_____