

Medical History

Office Use Only

Patient's Name _____

Name of Physician _____

Date of last physical exam _____

Are you currently under medical treatment? Yes No

If yes, describe condition _____

Do you have an allergy to latex products? Yes No

Do you use tobacco products? Yes No

Have you ever been diagnosed with a heart murmur? Yes No

Do you have high or low blood pressure? Yes No

Do you have diabetes? Yes No

Have you been diagnosed with cardiovascular disease? Yes No

(heart trouble, heart attack, angina or chest pain, stroke)

Have you ever had to take antibiotics prior to dental treatment? Yes No

For what condition? _____

Women - are you pregnant or trying to get pregnant? Yes No

Are you on birth control pills? Yes No

ALLERGIES:

Do you have an allergy to the following: Yes No

Penicillin or other antibiotics Yes No

Codeine, aspirin or any other pain relievers Yes No

Please list any other allergies you may have _____

Please check any of the following conditions that you may have or have had in the past:

Have you taken a bisphosphorate medication (typically taken to increase bone density or for bone cancers)

Hearing Loss / Hearing Aids Shortness of breath upon routine activities or light exercise

Asthma Heart abnormalities since birth

Liver Disease (hepatitis / jaundice) Fainting spells or seizures

Stomach ulcerations or problems Arthritis or joint problems

Tuberculosis Kidney trouble

Artificial joints, pins or plates Thyroid problems

Cancer Back problems

Type _____ Chemical dependency Type _____

Chemotherapy Radiation treatment

Emphysema HIV

Nervous disorders Sinus trouble

Swelling of the ankles

Bleeding disorders (bruise easily or bleeding for prolonged periods of time)

Please list all of your current medications and/or supplements and the conditions they are used for:

Do you have any other disease, condition or problem not listed above? Yes No

Please explain: _____

Patient signature: _____ Date _____