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
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 taking birth control pills? ❑ YES ❑ NO

ALLERGIES:

Do you have an allergy to the following:
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 bisphosphonate medication (typically taken to increase bone density or for bone cancers)
❑ Hearing Loss/Hearing Aids
❑ Asthma
❑ Liver Disease (hepatitis/jaundice)
❑ Stomach ulcerations or problems
❑ Tuberculosis
❑ Artificial joints, pins or plates
❑ Cancer
Type _____
❑ Chemotherapy
❑ Emphysema
❑ Nervous disorders
❑ Swelling of the ankles
❑ Heart abnormalities since birth
❑ Fainting spells or seizures
❑ Arthritis or joint problems
❑ Kidney trouble
❑ Thyroid problems
❑ Back problems
❑ Chemical dependency
Type _____
❑ Radiation treatment
❑ HIV
❑ Sinus trouble
❑ Bleeding disorders (bruise easily or bleeding for prolonged periods of time)
❑ Shortness of breath upon routine activities or light exercise

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 _____