Medical History Patient Name: _____ Date: _____

The following questions concerning your medical history and health are vital in planning your treatment, choosing medication, and insuring your health and well-being. Please answer all questions below as completely as possible. All information will be held in strict confidence. Your cooperation is necessary and appreciated.

Please answer each question by circling yes or no. Add any additional information if needed.

1. Do you consider yourself to be in good health?: **Y** **N**

2. Are you currently under the care of a physician?: **Y** **N**
   If yes, for what? _____

3. Are you currently on any medication or drugs? **Y** **N**
   What is the name of it? _____ What is the name of it? _____
   How long have you been on it? _____ How long have you been on it? _____
   What is it prescribed for? _____ What is it prescribed for? _____
   What is the dosage? _____ What is the dosage? _____
   How many times a day do you take it? _____ How many times a day do you take it? _____
   Do you expect to remain on it long term? _____ Do you expect to remain on it long term? _____
   (Please use the other side of this sheet for additional medications.)

4. Do you currently take an aspirin daily? (this includes baby aspirin) **Y** **N**

5. Do you take antibiotics before dental visits? (for heart disease or joint replacement) Y N

6. Do you have any allergies? (for medications or other) **Y** **N**
   If yes, to what? _____

My last medical examination was on: _____
The name and address of my physician is: Telephone #: ( ) -
_____

7. Have you ever had any of the following illnesses? **Y** **N** **(circle where appropriate)**

   a. Rheumatic fever, rheumatic heart disease or murmur
   b. Cardiovascular disease (high blood pressure, heart disease, stroke)
   c. Asthma, allergies, skin rash, hives
   d. Fainting spells or seizures
   e. Diabetes (type I or type II)
   f. Hepatitis, yellow jaundice of liver disease
   g. Arthritis, joint disease, artificial joints
   h. Thyroid disease
   i. Venereal diseases (gonorrhea, syphilis)
   j. Bleeding or clotting problems/disorders, anemia
   k. Cancer, tumor, growths
   l. AIDS, ARC, HIV infection
   m. Respiratory disease, sinus infections, COPD
   n. Drug or alcohol dependency
   o. Chemotherapy or radiation treatment
   (cxcluding diagnostic x-rays for fractures & dental treatment)

8. Do you have any disease, condition, or problem not listed above? **Y** **N**
   If yes, what? _____

9. Have you had any serious illness or operation? **Y** **N**
   If yes, what & when? _____

10. Have you ever had a serious accident? **Y** **N**
    What was the extent of the injuries? _____

(This form is continued on the reverse side)

11. Have you ever had an adverse, bad, or allergic reaction to: **Y** **N**

If yes, please circle which one(s) and briefly note problem.

a. Surgery
b. Dental Treatment
c. Medicines
d. Penicillin or other antibiotics
e. Local anesthetics (Novocaine, Lidocaine, Epinephrine)
f. Codeine, aspirin, or other pain relief medications

12. (For women) Are you currently or do you suspect you might be pregnant? **Y** **N**

13. Do you smoke? **Y** **N**
If yes, how much per day? _____

14. Do you use chewing tobacco? **Y** **N**

This is to certify that I consent and hereby authorize, and request the performance, upon myself or minor child, any dental procedure advisable or necessary. I also authorize and request the administration of local anesthetic(s) (such as Novocaine, Lidocaine) as deemed necessary or advisable by the doctor. I fully understand that dental medicine and surgery are not an exact science and that a precise outcome or perfect result cannot be guaranteed. I understand and acknowledge that I am financially responsible for the services provided regardless of insurance coverage.

Signature: _____ Date: _____

Parent's (or Guardian's) signature if patient is under 18 years old.

Notes/Additional Information: _____

_____

_____

_____

_____

_____

(for office use)

review of medical hx / / _____
update of medical hx / / _____
update of medical hx / / _____
update of medical hx / / _____
update of medical hx / / _____
update of medical hx / / _____