Medical History

Patient Name:_____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control? ☐ Yes ☐ No
Are you aware that antibiotics can decrease the effectiveness of birth control?

Check if you have the following:

MAY NEED TO PREMEDICATE BEFORE DENTAL APPOINTMENT

- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Breast Implants
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Mitral Valve Prolaspe
- ☐ Rheumatic Fever
- ☐ Have taken Phen-Fen or Redux

- ☐ Aids/HIV positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores/ Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Diabetes I ☐ II ☐
- ☐ Drug Addiction
- ☐ Excessive Bleeding
- ☐ Fainting Spells/ Dizziness
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Heart Attack/ Failure
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Pain In Jaw Joints
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Dialysis
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Sinus Trouble
- ☐ Stomach/ Intestinal Disease
- ☐ Stroke
- ☐ Tonsillitis
- ☐ Tumors or Growths
- ☐ Ulcers

Please list any disease, condition, or special need not listed:_____

_____

- Have you been admitted to a hospital or needed emergency care during the past 5 years? ☐ Yes ☐ No
  If Yes please explain:_____
- Are you under the care of a physician? ☐ Yes ☐ No
  If Yes please explain:_____
- Name of Physician:_____ Phone:_____

MEDICATIONS/HERBAL REMEDIES	ALLERGIES	
Please list any medications you are currently taking: _____ _____ _____ Pharmacy_____ _____	☐ Aspirin/ Ibuprofen ☐ Acrylic ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Metal	☐ Milk ☐ Penicillin ☐ Sedatives ☐ Sulfa ☐ Other_____ ☐ No known allergies

To the best of my knowledge, the above information is complete and correct. I understand that is my responsibility to inform my Doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient