Medical History

_______________ Patient Name   _______________ Month, Day, Year

In case of emergency we should notify:

Name ________________________________ Relationship____________________________ Day Time Phone__________________
Name of family MD _____________________ MD Phone # _____________________

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The Dentist will review the questions and explain any that you do not understand. Please fill out the entire form. Thank you.

1. Are you being treated for any medical condition at the present time, or have you been treated within the past year? If so, why?

   ____ ☐ Yes ☐ No ☐ Not sure

2. *When was your last medical check up?* ____

3. *Has there been any change in your general health in the past year? If yes, please explain* ☐ Yes ☐ No ☐ Not sure

4. *Are you taking any medications, non-prescription drugs, or herbal supplements of any kind?* ☐ Yes ☐ No ☐ Not sure

   If yes please list: ____

5. Do you have any allergies? If you answered yes, please list according to the categories below: ☐ Yes ☐ No ☐ Not sure

   Medications: ____

   Latex/Rubber products____

   Other (hay fever, foods etc)____

6. Have you ever had a peculiar or adverse reaction to any medicine or injections? ☐ Yes ☐ No ☐ Not sure

   If yes please explain____

7. Do you have or have you ever had Asthma? Bronchitis? Pneumonia? (If yes please circle which) ☐ Yes ☐ No ☐ Not sure

   ____

8. Do you have or have you ever had any heart or blood pressure problems? ☐ Yes ☐ No ☐ Not sure

   ____

9. *Do you have or have you ever had any heart valve repair or replacement?* ☐ Yes ☐ No ☐ Not sure

   ____

   Have you ever had any heart infection (infective endocarditis)? ☐ Yes ☐ No ☐ Not sure

   ____

   Have you ever had any congenital heard disease (from birth)? ☐ Yes ☐ No ☐ Not sure

   ____

10. Do you have a prosthetic or artificial joint? ☐ Yes ☐ No ☐ Not sure

    ____

11 *Do you have any conditions or therapies that could affect your immune system?* ☐ Yes ☐ No ☐ Not sure
(i.e. AIDS, HIV, Radiotherapy, Chemotherapy?)

12. *Have you ever had hepatitis, Jaundice or Liver disease?* ☐ Yes ☐ No ☐ Not sure

13. Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No ☐ Not sure

14. Have you ever had any operations? If yes please explain. ☐ Yes ☐ No ☐ Not sure

15. Do you have or have you ever had any of the following? Please check.

☐ *Chest pain, angina*	☐ rheumatic fever	☐ pacemaker	☐ steroid therapy	☐ seizures(epilepsy)
☐ stroke	☐ Heart attack	☐ mitral valve prolapse		☐ Lung disease
☐ Diabetes	☐ Kidney disease	☐ tuberculosis	☐ stomach ulcers	☐ Thyroid disease
☐ heart murmur	☐ Shortness of breath	☐ cancer	☐ arthritis	☐ drug dependency
☐ alcohol dependency	☐ Osteoporosis medication (Fosamax, Actonel)			

16. *Are there any conditions or diseases you have had not listed above?* ☐ Yes ☐ No ☐ Not sure

17. Are there any diseases or conditions that run in your family? ☐ Yes ☐ No ☐ Not sure

18. Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not sure

19. Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not sure

20. For women only: Are you breast feeding or pregnant? ☐ Yes ☐ No ☐ Not sure

To the best of my knowledge, the above information is correct:

____ *Date:*_________/______/____
Patient / Parent / Guardian/ Signature Month Day Year

____ *Date:*_________/______/____
Dentist's Signature Month Day Year

Dentist's notes: