



Medical History

Name: E-mail: Phone:

Are you in good health? Yes No Height: Weight:

Has there been any change in your general health? Yes No

Your last physical examination was on: Are you now under the care of a physician? Yes No

Name of your physician:

Address of your physician:

Have you ever had a serious illness or operation? Yes No

Have you been hospitalized with any of the following within the last 5 years?

Do you have a persistent cough or cough up blood? Yes No Low/High blood pressure(circle one) Yes No

Venereal Disease Yes No AIDS or HIV+ Yes No

Other:

Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes No

Do you bruise easily? Yes No

Have you ever required a blood transfusion Yes No

If yes, explain the circumstances:

Do you have any blood disorder such as anemia? Yes No

Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips? Yes No

Medications

Are you taking any drug or medication? Yes No

If yes, what?

Are you taking any of the following?

Antibiotics or sulfa drugs Yes No Tranquilizers Yes No

Cortisone (steroids)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medicine for high blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insulin, Tolbutamide (Orinase) or similar drug	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Digitalis or drugs for heart trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis Drugs (Fosamax, Aredia, Zometa etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anticoagulants (blood thinners such as Coumadin, Plavix etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nitroglycerin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any natural product, herbal supplement or homeopathic remedy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chemotherapy Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fen-Phen (now or in the past) or related drug such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramine), and Redux (dexfenfluramine)					
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Oral Contraceptives Yes No

If yes, what are you using?

Other:

Habits

Do you smoke? Yes No

If yes, how much?

Do you drink alcoholic beverages? Yes No Do you take any recreational drugs? Yes No

Do you have any of the following?

Cardiac pacemaker Yes No

A removable dental appliance Yes No

Implants/Artificial prosthesis (Knee joints, elbow pins etc) Yes No

Do you have, or have you had, any of the following diseases or problems?

Rheumatic fever or rheumatic heart disease Yes No

Hepatitis, jaundice, or liver disease Yes No

Heart Murmur or mitral valve prolapse Yes No

Congenital heart lesions Yes No

Convulsions/epilepsy Yes No

Stroke Yes No

Asthma or hay fever Yes No

Hives or skin rash Yes No

Fainting spells or seizures Yes No

Arthritis Yes No

Inflammatory rheumatism (painful, swollen joints) Yes No Stomach ulcers Yes No

Kidney trouble Yes No Tuberculosis Yes No

A tumor or growth Yes No Radiation therapy or chemotherapy Yes No

Thyroid trouble Yes No Bleeding tendency /abnormal bleeding Yes No

Are you immunosuppressed? Possibly from transplant surgery Yes No

Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)

Yes No

Do you have pain in the chest upon exertion? Yes No

Are you ever short of breath after mild exercise? Yes No

Do you get short of breath when you lie down or do you require extra pillows when you sleep? Yes No

Diabetes Yes No

Do you have to urinate (pass water) more than six (6) times a day? Yes No

Are you thirsty much of the time? Yes No

Does your mouth frequently become dry? Yes No

Allergy

Are you allergic or have you reacted adversely to:

Local anesthetic Yes No Barbiturates, sedatives, or sleeping pills Yes No

Sulfa Drugs Yes No Codeine Yes No

Valium or other tranquilizer Yes No Aspirin Yes No

Iodine Yes No Latex Yes No

Penicillin or other antibiotics (such as amoxicillin, clindamycin, erythromycin, Keflex etc) Yes No

Other:

Have you had any serious trouble associated with previous dental treatment? Yes No

If yes, explain:

For Women Only

Are you pregnant or could you be? Yes No

If yes, when are you due?

Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

If yes, what?

Comments:

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist or my surgeon before my next visit.

Patient's Signature:

Date:

Guardian's Signature:

Date:

Doctor's Signature:

Date: