

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)	Yes	No	Medicine for high blood pressure	Yes	No
Insulin, Tolbutamide (Orinase) or similar drug	Yes	No	Digitalis or drugs for heart trouble	Yes	No
Osteoporosis Drugs (Fosamax, Aredia, Zometa etc.)	Yes	No	Aspirin	Yes	No
Anticoagulants (blood thinners such as Coumadin, Plavix etc)	Yes	No	Nitroglycerin	Yes	No
Any natural product, herbal supplement or homeopathic remedy?	Yes	No	Chemotherapy Drugs	Yes	No
Fen-Phen (now or in the past) or related drug such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramine), and Redux (dexfenfluramine)					
		Yes	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
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Kidney trouble	Yes	No	Tuberculosis	Yes	No
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A tumor or growth	Yes	No	Radiation therapy or chemotherapy	Yes	No
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Thyroid trouble	Yes	No	Bleeding tendency /abnormal bleeding	Yes	No
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Are you immunosuppressed? Possibly from transplant surgery	Yes	No
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Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)	Yes	No
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Do you have pain in the chest upon exertion?	Yes	No
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Are you ever short of breath after mild exercise?	Yes	No
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Do you get short of breath when you lie down or do you require extra pillows when you sleep?	Yes	No
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Diabetes	Yes	No
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Do you have to urinate (pass water) more than six (6) times a day?	Yes	No
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Are you thirsty much of the time?	Yes	No
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Does your mouth frequently become dry?	Yes	No
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Allergy

Are you allergic or have you reacted adversely to:	
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Local anesthetic	Yes	No	Barbiturates, sedatives, or sleeping pills	Yes	No
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Sulfa Drugs	Yes	No	Codeine	Yes	No
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Valium or other tranquilizer	Yes	No	Aspirin	Yes	No
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Iodine	Yes	No	Latex	Yes	No
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Penicillin or other antibiotics (such as amoxicillin, clindamycin, erythromycin, Keflex etc)	Yes	No
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Other:	
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Have you had any serious trouble associated with previous dental treatment?	Yes	No
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If yes, explain:	
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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: