MEDICAL HISTORY

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 in the entire form.

PATIENT NAME ______________________________________

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

   ❐ YES ❐ NO ______________________________________

2. When was your last medical checkup? __________________

3. Has there been any change in your general health in the past year? If yes, please explain.

   ❐ YES ❐ NO ______________________________________

4. Are you taking any medications, non-prescription *drugs* or herbal supplements of any kind? If yes, please list.

   ❐ YES ❐ NO ______________________________________
   ____

5. Do you have any allergies? If you answered yes, please list using the categories below:

   ❐ YES ❐ NO

   a) medications ______________________________________
   b) latex/rubber products ____________________________
   c) other, e.g hay fever, foods _________________________

6. Have you ever had a peculiar or adverse reaction to any medications or injections? If yes, please explain.

   ❐ YES ❐ NO

7. Do you have or have you ever had any heart or blood pressure problems?

   ❐ YES ❐ NO ______________________________________

8. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?

   ❐ YES ❐ NO ______________________________________

9. Do you have a prosthetic or artificial joint?

   ❐ YES ❐ NO

10. Have you ever been advised by your doctor to take premedication (antibiotics) before dental treatment?

    ❐ YES ❐ NO

11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy).

    ❐ YES ❐ NO ______________________________________

12. Have you ever had hepatitis, jaundice or liver disease?

    ❐ YES ❐ NO

13. Do you have a bleeding problem or bleeding disorder?

    ❐ YES ❐ NO ______________________________________

14. Have you ever been hospitalized for any illness or operations? If yes, please explain.

    ❐ YES ❐ NO ______________________________________

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

    ❐ arthritis
    ❐ asthma
    ❐ cancer
    ❐ chest pain, angina
    ❐ diabetes
    ❐ diet pill therapy
    ❐ heart attack
    ❐ kidney disease
    ❐ lung disease
    ❐ pacemaker
    ❐ prosthetic heart valve
    ❐ seizures (epilepsy)
    ❐ shortness of breath
    ❐ steroid therapy
    ❐ stomach ulcers
    ❐ stroke
    ❐ thyroid disease
    ❐ tuberculosis

16. Are there any conditions or disease not listed above that you have or have had? If so, what?

    ❐ YES ❐ NO ______________________________________
    ____

17. Do you smoke?

    ❐ YES ❐ NO

18. Does your jaw crack or pop when opened wide?

    ❐ YES ❐ NO

19. **For women only:** Are you pregnant or breast -feeding? If pregnant, what is the expected delivery date?

    ❐ YES ❐ NO ______________________________________

In order to avoid complications as a result of a change in your medical condition, it is important you notify this office of any changes.