MEDICAL HISTORY

Please do not use N/A (Not Applicable)

Patient's Name_____ DOB _____

Your Dentist _____ Your Physician _____ Referred by: _____

Has your doctor ever recommended a pre-med before dental treatment? _____Yes _____No

Why are you here today? _____

List medical problems, hospitalizations, operations, etc.: _____

List medications you take regularly: _____

List any herbal remedies you take: _____

List allergies to medications such as penicillin, codeine, hydrocodone, others: If so rash, swelling, upset stomach:

_____

DO YOU HAVE OR HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING?

Please check:

____ heart murmur
____ rheumatic fever
____ rheumatic heart disease
____ joint replacement
____ heart valve replacement
____ diabetes:
____oral ____insulin
____ chest pain
____ shortness of breath
____ stroke
____ heart attack
____ arteriosclerosis
____ high blood pressure
____ pace maker
____ sleep with 2 or more pillows
____ swelling of ankles
____ lung or chest disease
____ asthma
____ tobacco
____ in pain clinic
____ latex allergies
____ cancer patient
Type: _____

____ cough more than 3 weeks
____ unexplained weight loss
____ night sweats
____ medications to thin blood
____ anemia
____ bleeding problems
____ stomach problems/ulcers
____ bowel problems
____ gallbladder problems
____ hepatitis
____ liver disease
____ jaundice
____ kidney disease
____ glaucoma
____ thyroid or glandular disease
____ fainting spells, seizures, convulsions
____ arthritis
____ joint pain
____ sexually transmitted disease
____ AIDS blood test neg___ pos___
____ are you pregnant?
____ others_____

I verify the accuracy of the above information: Signature _____Date_____