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.

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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 change.

NAME:______________________________ DATE: ________