



MEDICAL HISTORY

Patient Name: _____

DOB: _____

Please Answer YES or NO:

Are you under the active care of a physician or specialist? _____

Have you ever been hospitalized or had major surgery? _____

If yes, When/Why? _____

Are you pregnant? _____ Nursing? _____ Trying to get pregnant? _____

Do you pre-medicate with antibiotics prior to dental treatment due to an artificial joint replacement or heart issue? _____ If yes, what antibiotic? _____

Have you experienced an unfavorable reaction to previous dental treatment? _____

Do you currently, or have you ever taken Bisphosphonates/ Bone Density Medications? _____

If yes, which one? _____ Last taken: _____

Please list all medications you are currently taking: _____

Check the following you have had / currently have:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> HEPATITIS OR JAUNDICE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEART MURMUR |
| <input type="checkbox"/> LIVER PROBLEMS | <input type="checkbox"/> ASTHMA/BREATHING ISSUES | <input type="checkbox"/> ENDOCARDITIS | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> HEART VALVE REPLACEMENT | <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> LUNG DISORDER | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> VENEREAL DISEASE | <input type="checkbox"/> THYROID DISORDER | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> CANCER | <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> HERPES |
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> STROKE | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> NERVOUS DISORDER |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> BLOOD DISORDER | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> ARTIFICIAL JOINT |
| <input type="checkbox"/> BLOOD TRANSFUSION | <input type="checkbox"/> RADIATION THERAPY | <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> DRUG ADDICTION |

Other: _____

ALLERGIES:

Antibiotics: _____ Pain Medications: _____

Dental Anesthetics: _____ Latex: _____

None: _____ Other: _____

Signature: _____

Date: _____

Patient, Parent or Guardian