

Medical History

Patient Name: _____ Birthdate: _____ M/F _____

Physician Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

The information requested below will be held in strict confidence. Please answer all questions as accurately and completely as possible to help us provide you with the best and safest care.

Yes No 1) Are you under the care of a physician at this time?
If yes, for what condition? If no, date of last visit.

Yes No 2) Have you had any serious illness, operation or been hospitalized in the past 5 years?
If yes, for what condition?

Yes No 3) Are you taking any prescription and/or over the counter drugs or medications?
If yes, please list:

Yes No 4) Are you allergic to any of the following? Circle if yes

Penicillin	Sulfa drugs	Codeine	Valium
Tetracycline	Ibuprofen	Latex	Other Sedatives
Erythromycin	Aspirin	Dental Anesthetics	
Other: _____			

Yes No 5) Are you taking Tagamet (Cimetidine)?

Yes No 6) Do you take antacids?

Yes No 7) Are you taking herbal supplements/medicines? What? _____

Yes No 8) Do you have any bleeding/clotting problems?

Yes No 9) Have you ever taken appetite suppressant drugs such as Phen-Fen?

Yes No 10) Do you smoke or chew tobacco?

Yes No 11) Do you consume grapefruits, grapefruit juice, or grapefruit extract?

Over ↪

8) Do you have or have you had any of the following diseases? Please circle yes or no

- | | | | | | |
|-----|----|--|-----|----|---|
| Yes | No | A) Damaged heart valve, heart murmur, | Yes | No | K) Diabetes |
| Yes | No | B) Pacemaker, artificial heart valve,
heart surgery | Yes | No | L) Fainting spells, epilepsy
or convulsions |
| Yes | No | C) Heart disease or heart condition,
heart defect from birth, heart
attack, angina, stroke | Yes | No | M) Thyroid problems or goiter |
| Yes | No | D) Current or recent chest pain,
shortness of breath/swollen ankles | Yes | No | N) Kidney disease |
| Yes | No | E) Prosthetic devices such as
joint replacements/implants | Yes | No | O) Sexually transmitted diseases
such as herpes or gonorrhea |
| Yes | No | F) Blood transfusions | Yes | No | P) HIV infection or AIDS |
| Yes | No | G) High Blood Pressure | Yes | No | Q) Treatment for cancer, tumors,
radiation or chemotherapy |
| Yes | No | H) Asthma, emphysema, lung or
respiratory, conditions including
frequent sinus infections | Yes | No | R) Arthritis or rheumatism |
| Yes | No | I) Active tuberculosis or persistent
cough that produces bloody mucous | Yes | No | S) Anemia or low blood cell count |
| Yes | No | J) Hepatitis, jaundice, cirrhosis or
liver disease | Yes | No | T) Psychiatric treatment,
depression or nervousness |

For Women

- Yes No U) Are you taking birth control pills?
Yes No V) Are you pregnant?
Yes No W) Are you nursing?

Informed Consent

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature

Date

Comments: For Dr's Use Only