MEDICAL HISTORY

(PLEASE FILL OUT BOTH SIDES OF FORM)

Patient Name (please print): _____ Today's Date: _____

If you are completing this form for another person, what is your relationship to that person?

Your Name (please print): _____ Relationship: _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. **ALL INFORMATION YOU PROVIDE WILL BE KEPT CONFIDENTIAL.**

1. Are you in good health? _____
2. Has there been any change in your health in the past year? _____
3. Date of last physical exam: _____ Physician: _____ Phone #: _____
4. Are you being treated by a physician for any reason at present? _____

   If so, for what condition? _____ Physician: _____
5. Have you had a serious illness, operation or hospitalization within the past 5 years?
   If so, describe and give dates _____
6. Have you had an orthopedic joint replacement (knee, hip, elbow, finger, shoulder)? _____
   If so, when? _____
7. Do you require antibiotic premedication for dental treatment? _____
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis, chemotherapy for multiple myeloma, other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa)? _____
9. Have you ever been advised **not** to take a medication? _____
10. Are you taking or have you recently taken any prescription or over the counter medicine(s)?
    If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____

_____

_____

_____

WOMEN ONLY: Are you Pregnant? _____ Number of weeks: _____

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

11. **Do you have or have you had any of the following diseases or problems?**

A.	Rheumatic Fever or Rheumatic Heart Disease.....	Y N
B.	Congenital Heart Disease.....	Y N
C.	Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, Stroke, Palpitations, Mitral Valve Prolapse, Heart Surgery, Pacemaker).....	Y N
D.	High/Low Blood Pressure.....	Y N
E.	Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing).....	Y N
F.	Seizures, Convulsions, Epilepsy, Fainting or Dizziness.....	Y N
G.	Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion, Bruise Easily.....	Y N

(OVER)

H. Liver Disease (Jaundice, Hepatitis)..... Y N
I. Kidney Disease..... Y N
J. Diabetes..... Y N
K. Thyroid Disease (Goiter)..... Y N
L. Arthritis..... Y N
M. Stomach Ulcers or Colitis..... Y N
N. Glaucoma..... Y N
O. Osteoporosis..... Y N
P. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)..... Y N
Q. Radiation (X-ray) treatment for Cancer..... Y N
R. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth..... Y N
S. Sinus or Nasal problems..... Y N
T. Any disease, or transplant operation that has depressed your Immune system..... Y N
U. Mental health disorders..... Y N
If so, specify _____
V. Severe headaches/migraines..... Y N
W. AIDS or HIV infection..... Y N
X. Recurrent infections of any kind..... Y N

Are you allergic to or have you had any unusual reactions to:

12. Penicillin, Amoxicillin, Cephalosporins, Erythromycin, Azithromycin, Clindamycin..... Y N
13. Other antibiotics..... Y N
14. Local anesthetic (Novocaine—like drugs)..... Y N
15. Barbiturates, sedatives..... Y N
16. Aspirin, Ibuprofen, NSAIDS, or other pain medications..... Y N
17. Codeine or other narcotics..... Y N
18. Latex or rubber products..... Y N
19. Other allergies or reactions..... Y N
Please list:_____

_____

Do you have any disease, condition, or problem not listed above? _____

_____

Do you wish to talk to the Doctor privately about anything? ..... Y N

Note: The patient is encouraged to discuss any and all relevant health issues, with the doctor, prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____ _____

Signature of Patient/Legal Guardian **Date** **Doctor's Initials**

THANK YOU. Please return this form to the receptionist before completing others: **(3/18)**

FOR COMPLETION BY DENTIST

Comments:

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