Medical History

Name _____ Date _____

Last First Middle

1. Are you in good health? _____ YES NO N/A ?

2. Have there been any changes to your health in the past year? _____ YES NO N/A ?

3. Are you currently under the care of a physician? _____ YES NO N/A ?
   a. If so, what was the problem? _____

4. Do you have or have you had any of the following:
   a. Rheumatic fever / heart murmur _____ YES NO N/A ?
   b. Heart valve replacement / mitral valve prolapse _____ YES NO N/A ?
   c. High blood pressure _____ YES NO N/A ?
   d. Low blood pressure _____ YES NO N/A ?
   e. Heart trouble (heart attack, stroke, other) _____ YES NO N/A ?
   f. Cardiac pacemaker _____ YES NO N/A ?
   g. Prosthetic joint or implant _____ YES NO N/A ?
      If so, where? _____
   h. Bronchitis / Tuberculosis / Emphysema _____ YES NO N/A ?
   i. Asthma _____ YES NO N/A ?
   j. Hay fever / sinus problems _____ YES NO N/A ?
   k. Abnormal bleeding / anemia _____ YES NO N/A ?
   l. Jaundice, hepatitis or liver disease _____ YES NO N/A ?
   m. Diabetes / low blood sugar _____ YES NO N/A ?
   n. Kidney trouble _____ YES NO N/A ?
   o. Stomach ulcers _____ YES NO N/A ?
   p. Herpes, AIDS, or HIV _____ YES NO N/A ?
   q. Radiation treatment / Chemotherapy / Cancer _____ YES NO N/A ?
   r. A history of drug / alcohol abuse _____ YES NO N/A ?
   s. Eye disease / glaucoma _____ YES NO N/A ?

5. Are you now taking:
   a. Blood thinners (Coumadin, Aspirin, Ibuprofen) _____ YES NO N/A ?
   b. Tranquilizers _____ YES NO N/A ?
   c. Bone density medications or Bisphosphonates (Arecila, Zometa, Fosamax, Actonel) _____ YES NO N/A ?
   d. Are you taking any drugs or medicine other than those listed above? _____ YES NO N/A ?
      If so, what? _____

6. Are you allergic too or had a reaction to:
   a. Local anesthetics _____ YES NO N/A ?
   b. Penicillin or other antibiotics _____ YES NO N/A ?

c. Aspirin _____ YES NO N/A ?

d. Barbiturates, sedatives, or sleeping pills _____ YES NO N/A ?

e. Aspirin _____ YES NO N/A ?

f. Codeine, morphine, demerol or other narcotics _____ YES NO N/A ?

g. Latex products _____ YES NO N/A ?

h. Sulfides _____ YES NO N/A ?

i. Other _____

6. For women only:

a. Is there any possibility that you are currently pregnant? _____ YES NO N/A ?

If so, when are you due to deliver? _____

b. Are you currently nursing? _____ YES NO N/A ?

c. Are you currently taking birth control? _____ YES NO N/A ?

IF YOU ARE TAKING BIRTH CONTROL PILLS, PLEASE READ THE FOLLOWING: Antibiotics may inactivate birth control medication. If you are prescribed antibiotics during endodontic treatment, additional birth control methods should be used until your next menses.

9. Is this visit related to an accident? _____ YES NO N/A ?

10. In case of emergency who should be contacted? _____

_____

Signature of Patient

_____

Signature of Dentist