PATIENT MEDICAL HISTORY

PATIENT NAME _____ TODAY'S DATE _____

MEDICAL DOCTOR _____ OFFICE PHONE_____ DATE OF LAST EXAM_____

ARE YOU UNDER MEDICAL TREATMENT NOW? **Y N**

HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? **Y N**
_____

DO YOU HAVE ANY SURGERIES SCHEDULED IN THE NEXT 7 DAYS? _____ **Y N**

DO YOU USE TOBACCO?_____ **Y N**

DO YOU, OR HAVE YOU USED CONTROLLED SUBSTANCES? **Y N**
IF YES, EXPLAIN_____

DO YOU, OR HAVE YOU TAKEN PHEN-FEN, REDUX, OR ORAL BISPHOSPHONATES? **Y N**

ARE YOU CURRENTLY TAKING ANY BLOOD THINNERS? **Y N**

DO YOUR GUMS BLEED EASILY? **Y N**

DO YOU SUFFER FROM COLD SORES/CANKER SORES? **Y N**

ARE YOU INTERESTED IN WHITENING YOUR TEETH? **Y N**

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? _____ **Y N**

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ PENICILLIN ☐ SULFA DRUGS ☐ BARBITUATES ☐ LOCAL ANESTHETICS ☐ NONE

☐ IODINE ☐ LATEX ☐ SEDATIVES ☐ ASPIRIN ☐ OTHER_____

WOMEN ONLY

ARE YOU PREGNANT OR TRYING TO GET PREGNANT? **Y N** ARE YOU NURSING? **Y N** ARE YOU TAKING ORAL CONTRACEPTIVES? **Y N**

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING?

HIGH BLOOD PRESSURE	**Y N**	DIABETES	**Y N**	ARTHRITIS	**Y N**
LOW BLOOD PRESSURE	**Y N**	GLAUCOMA	**Y N**	HEPATITIS / JAUNDICE	**Y N**
HEART ATTACK	**Y N**	CANCER	**Y N**	SEXUALLY TRANSMITTED DISEASE	**Y N**
HEART MURMUR	**Y N**	LEUKEMIA	**Y N**	AIDS OR HIV INFECTION	**Y N**
HEART DISEASE	**Y N**	RADIATION THERAPY	**Y N**	ANEMIA	**Y N**
CARDIAC PACEMAKER	**Y N**	CHEMOTHERAPY (PORT Y/N)	**Y N**	ALZHEIMER'S/ DEMENTIA	**Y N**
ANGINA	**Y N**	DIALYSIS (PORT Y/N)	**Y N**	LIVER DISEASE	**Y N**
ARTIFICIAL HEART VALVE / STENT	**Y N**	KIDNEY DISEASE	**Y N**	HAY FEVER / ALLERGIES	**Y N**
CONGESTIVE HEART FAILURE	**Y N**	ASTHMA	**Y N**	TUBERCULOSIS	**Y N**
MITRAL VALVE PROLAPSE	**Y N**	EMPHYSEMA	**Y N**	RECENT WEIGHT LOSS	**Y N**
ARRHYTHMIA	**Y N**	RESPIRATORY PROBLEMS	**Y N**	PSYCHIATRIC CARE	**Y N**
STROKE	**Y N**	EPILEPSY / CONVULSIONS	**Y N**	STOMACH TROUBLES / ULCERS	**Y N**
RHEUMATIC FEVER	**Y N**	THYROID PROBLEM	**Y N**	OTHER:_____	
JOINT REPLACEMENT OR IMPLANT	**Y N** - TYPE_____				

MEDICATIONS

_____

_____

_____

_____

_____

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_____

SIGNATURE OF DENTIST: **DATE:**

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____
PATIENT, PARENT, OR GUARDIAN DATE

X _____
PATIENT, PARENT, OR GUARDIAN DATE

X _____
PATIENT, PARENT, OR GUARDIAN DATE

X _____
PATIENT, PARENT, OR GUARDIAN DATE