PATIENT NAME: _____ DATE: _____

Yes No

____ ____ 1. Do you have a current medical problem?
____ ____ 2. Are you currently under the care of a physician?
____ ____ 3. Have you been hospitalized or had a serious illness within the past 5 years?
____ ____ 4. Do you have heart trouble or any form of cardiovascular disease?

____ Angina (chest pains) Frequency _____
____ Heart Attack (date) _____
Heart surgery (date)
____ pacemaker
____ bypass
____ prosthetic heart valve
____ Stroke (date) _____
____ Rheumatic fever (date) _____
____ Heart murmur
____ High blood pressure
____ Congenital Heart lesions
____ Atherosclerosis
____ Osteoporosis

____ ____ 5. Do you have diabetes? If YES, how is it controlled? _____
____ ____ 6. Do you have kidney disease?
____ ____ 7. Have you ever had hepatitis? (Date) _____
____ Type A infectious (Food) ____ Type B serum (Blood)
____ Unknown (explain) _____
____ ____ 8. Have you ever had liver disease or jaundice? (date) _____
____ ____ 9. Do you have any blood disease?
____ Anemia ____ AIDS or positive test ____ Leukemia ____ Venereal disease
____ ____ 10. Do you have any problems with excessive bleeding? If YES, explain _____
____ ____ 11. Do you have stomach or intestinal ulcers?
____ ____ 12. Have you ever had tuberculosis? (date) _____
____ ____ 13. Do you have emphysema, asthma or breathing problems?
____ ____ 14. Have you had a hip or other joint replacement?
____ ____ 15. Have you ever had any injury, pain or soreness from your jaw joint? (TMJ dysfunction)
____ ____ 16. Have you ever had any chronic head, neck or back pain problems?
____ ____ 17. Have you ever suffered trauma to your head or neck, such as in a car accident?
If YES, please describe _____
____ ____ 18. Do you have fainting spells, convulsions or epilepsy?
____ ____ 19. Have you had surgery, radiation or other treatment for a tumor or growth?
____ ____ 20. Is your diet medically prescribed? If YES, explain _____
____ ____ 21. Are you pregnant? (Expected delivery date) _____
____ ____ 22. Do you have a history of previous miscarriages?
____ ____ 23. Have you reached menopause? If YES, what hormones are you taking? _____
____ ____ 24. Are you allergic to or have you had any unusual reactions to any of the following:

____ Penicillin
____ Erythromycin ____ Latex
____ Sulfa Drugs
____ Other antibiotics _____
_____
____ Codeine
____ Aspirin
____ Other pain medications _____
_____
____ Local anesthetics
____ Novocain
____ Xylocaine
____ Nitrous oxide
____ Epinephrine
____ Barbiturates
____ Sleeping pills
____ Any other drug allergies? _____
_____

____ ____ 25. Have you ever been advised not to take a particular medication? _____
If YES, please list _____
____ ____ 26. Have you ever been advised to premedicate with antibiotics before dental treatment?
____ ____ 27. Please list any medications you are currently taking:

_____ Reason: _____
_____ Reason: _____
_____ Reason: _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation.

Signature _____ Date _____

Current physician _____
name city, state phone

Changes in medical history:

_____ _____ _____ _____
change date change date

_____ _____ _____ _____ _____ _____
change date change date change date

Medical history reviewed: _____ _____ _____ _____ _____ _____ _____ _____