MEDICAL HISTORY FORM

All information is kept confidential. Accurate and complete information will help us to treat you with the utmost care.

Title:____First:__________________MI ___Last:______________________________Today's Date:________________

Do you, or have you ever, had any of the following?	Yes	No	Unknown	Comments
Are you in good health at this time?	[ ]	[ ]	[ ]	________
Have you been under the care of a physician in the past 2 years?	[ ]	[ ]	[ ]	________
If yes, why?________				
Have you ever been told you need **PREMEDICATION** with antibiotics before dental visits? (e.g. for an artificial joint)?				
If yes, which medication and dose?________	[ ]	[ ]	[ ]	________
Have you ever reacted to latex based products?	[ ]	[ ]	[ ]	________
If yes, what has your reaction been? ________				
Have you ever had excessive bleeding requiring special treatment?	[ ]	[ ]	[ ]	________
If yes, please explain ________				
Have you ever been tested for HIV ("AIDS" test)?	[ ]	[ ]	[ ]	________
When was the test done? ________				
Was the test positive or negative?	[ ]	[ ]	[ ]	________
Heart trouble	[ ]	[ ]	[ ]	________
Pacemaker	[ ]	[ ]	[ ]	________
Congenital heart defects	[ ]	[ ]	[ ]	________
Heart murmur	[ ]	[ ]	[ ]	________
Mitral valve prolapse	[ ]	[ ]	[ ]	________
High blood pressure	[ ]	[ ]	[ ]	________
Low blood pressure	[ ]	[ ]	[ ]	________
Rheumatic fever	[ ]	[ ]	[ ]	________
Anemia	[ ]	[ ]	[ ]	________
Prosthetic surgery	[ ]	[ ]	[ ]	________
Artificial hip / knee / other joint	[ ]	[ ]	[ ]	________
Sexually transmitted diseases (HPV, Herpes, HIV etc.)	[ ]	[ ]	[ ]	________
Temporomandibular joint (TMJ) problems	[ ]	[ ]	[ ]	________
Osteoporosis	[ ]	[ ]	[ ]	________
Depression	[ ]	[ ]	[ ]	________
Eating Disorder	[ ]	[ ]	[ ]	________
Psychiatric treatment	[ ]	[ ]	[ ]	________
Tuberculosis	[ ]	[ ]	[ ]	________
Diabetes: Type______	[ ]	[ ]	[ ]	________
Hepatitis: Type______	[ ]	[ ]	[ ]	________
Arthritis	[ ]	[ ]	[ ]	________
Stroke	[ ]	[ ]	[ ]	________
Epilepsy: Type______	[ ]	[ ]	[ ]	________
Jaundice	[ ]	[ ]	[ ]	________
Sinus Trouble	[ ]	[ ]	[ ]	________
Stomach / digestive problems	[ ]	[ ]	[ ]	________
Have you ever smoked or used chewing tobacco? How much?	[ ]	[ ]	[ ]	________
Cancer / tumors Type________ Date________	[ ]	[ ]	[ ]	________
Radiation therapy Amount________ Location________	[ ]	[ ]	[ ]	________
Chemotherapy Type________ Date________	[ ]	[ ]	[ ]	________
(Women) Are you pregnant now? If yes, due date?________	[ ]	[ ]	[ ]	________
Is there any other medical problem you feel we should be aware of?	[ ]	[ ]	[ ]	________
Are you allergic to **Penicillin or any drugs or medications**	[ ]	[ ]	[ ]	________

If yes, which ones: ________ ________ ________ ________ ________

Please list all medications, prescription and over-the-counter, that you are currently taking:________ ________

________ ________ ________ ________ ________ ________

________ ________ ________ ________ ________ ________

Patient / Guardian Signature: ____________________Relationship:________ Date:________

***Office use only**: Entered by:________________Entered on:________________*