# 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:________________________*