MEDICAL HISTORY

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

   ❒ YES ❒ NO _____

2. When was your last medical checkup? _____

3. Has there been any change in your general health in the past year? If yes, please explain.

   ❒ YES ❒ NO _____

4. Are you taking any medications, non-prescription *drugs* or herbal supplements of any kind? If yes, please list.

   ❒ YES ❒ NO _____
   _____

5. Do you have any allergies? If you answered yes, please list using the categories below:

   ❒ YES ❒ NO

   a) medications _____
   b) latex/rubber products _____
   c) other, e.g hay fever, foods _____

6. Have you ever had a peculiar or adverse reaction to any medications or injections? If yes, please explain.

   ❒ YES ❒ NO

7. Do you have or have you ever had any heart or blood pressure problems?

   ❒ YES ❒ NO _____

8. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?

   ❒ YES ❒ NO _____

9. Do you have a prosthetic or artificial joint?

   ❒ YES ❒ NO

10. Have you ever been advised by your doctor to take premedication (antibiotics) before dental treatment?

    ❒ YES ❒ NO

11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy).

    ❒ YES ❒ NO _____

12. Have you ever had hepatitis, jaundice or liver disease?

    ❒ YES ❒ NO

13. Do you have a bleeding problem or bleeding disorder?

    ❒ YES ❒ NO _____

14. Have you ever been hospitalized for any illness or operations? If yes, please explain.

    ❒ YES ❒ NO _____

15. Do you have or have you ever had any of the following? Please check.

    ❒ arthritis
    ❒ asthma
    ❒ cancer
    ❒ chest pain, angina
    ❒ diabetes
    ❒ diet pill therapy
    ❒ heart attack
    ❒ kidney disease
    ❒ lung disease
    ❒ pacemaker
    ❒ prosthetic heart valve
    ❒ seizures (epilepsy)
    ❒ shortness of breath
    ❒ steroid therapy
    ❒ stomach ulcers
    ❒ stroke
    ❒ thyroid disease
    ❒ tuberculosis

16. Are there any conditions or disease not listed above that you have or have had? If so, what?

    ❒ YES ❒ NO _____
    _____

17. Do you smoke?

    ❒ YES ❒ NO

18. Does your jaw crack or pop when opened wide?

    ❒ YES ❒ NO

19. **For women only:** Are you pregnant or breast -feeding? If pregnant, what is the expected delivery date?

    ❒ YES ❒ NO _____

In order to avoid complications as a result of a change in your medical condition, it is important you notify this office of any change.

NAME:_____ DATE: _____