Medical History Form

Emergency Contact _____

Emergency Contact Phone _____

Emergency Contact Relationship _____

DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS

- ◯ Active Tuberculosis
- ◯ Persistent cough greater than a 3 week duration
- ◯ Cough that produces blood
- ◯ Been exposed to anyone with Tuberculosis

MEDICAL HISTORY

Are you now under the care of a physician?

Physician Name _____ Phone _____

Are you in good health? YES ◯ NO ◯ Any change in your health within the past year? YES ◯ NO ◯

Have you had a serious illness or been hospitalized in the past 5 years? YES ◯ NO ◯

Are you taking or have you recently taken any prescription or over the counter medicine(s)? YES ◯ NO ◯

IF so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

_____

Have you had any orthopedic total joint replacement? YES ◯ NO ◯ DATE _____

Do you use controlled substances (drugs)? YES ◯ NO ◯ Do you use tobacco? YES ◯ NO ◯

Do you drink alcoholic beverages? YES ◯ NO ◯

WOMAN ONLY. Are you:

Pregnant YES ◯ NO ◯ Number of weeks _____

Taking Birth control pills? YES ◯ NO ◯ Nursing? YES ◯ NO ◯

ALLERGIES, ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTION TO

- ◯ Local anesthetics
- ◯ Aspirin
- ◯ Penicillin or other antibiotics
- ◯ Sedatives or sleeping pills
- ◯ Sulfa drugs
- ◯ Codeine or other narcotics
- ◯ Metals
- ◯ Latex (rubber)
- ◯ Iodine
- ◯ Hay fever/seasonal
- ◯ Animals
- ◯ Food

Other (please specify): _____

CONGENITAL HEART DISEASE (CHD) PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING;

- ◯ Artificial (prosthetic) heart valve
- ◯ Previous infective endocarditis
- ◯ Damaged valves in transplanted heart
- ◯ Congenital heart disease (CHD)
- ◯ Unrepaired, cyanotic CHD
- ◯ Repaired (completely) in the last 6 months
- ◯ Repaired CHD with residual defects

OTHER DISEASES AND CONDITIONS - Please indicate if you have had or not had any of the following:

- ◯ Cardiovascular disease
- ◯ Angina
- ◯ Arteriosclerosis
- ◯ Congestive heart failure
- ◯ Damaged heart valves
- ◯ Hearth attack
- ◯ Heart murmur
- ◯ Low blood pressure
- ◯ High blood pressure
- ◯ Other heart defects
- ◯ Mitral valve prolapse
- ◯ Pacemaker
- ◯ Rheumatic fever
- ◯ Rheumatic heart disease
- ◯ Abnormal bleeding
- ◯ Anemia
- ◯ Blood transfusion
- ◯ Hemophilia
- ◯ AIDS or HIV
- ◯ Arthritis
- ◯ Autoimmune disease
- ◯ Rheumatoid arthritis
- ◯ Systemic lupus erythematosus
- ◯ Asthma
- ◯ Bronchitis
- ◯ Emphysema
- ◯ Sinus trouble
- ◯ Tuberculosis
- ◯ Cancer/Chemotherapy/Radiation
- ◯ Chest pain upon exertion
- ◯ Chronic pain
- ◯ Diabetes Type I or II
- ◯ Eating disorder
- ◯ Malnutrition
- ◯ Gastrointestinal disease
- ◯ G.E Reflux/persistent heartburn
- ◯ Thyroid problems
- ◯ Stroke
- ◯ Glaucoma
- ◯ Hepatitis, jaundice or liver disease
- ◯ Epilepsy
- ◯ Fainting spells or seizures
- ◯ Neurological disorders
- ◯ Sleep disorder
- ◯ Mental health disorders
- ◯ Recurrent infections
- ◯ Kidney problems
- ◯ Night sweats
- ◯ Osteoporosis
- ◯ Persistent swollen glands in neck
- ◯ Severe Headaches/migraines
- ◯ Severe or rapid weight loss
- ◯ Sexually transmitted disease
- ◯ Excessive urination

PREMEDICATION

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, please list their name and number.

Do you have any disease, condition, or problem not listed above that you think I should know about?

SIGNATURE _____ DATE _____