NAME ____

LAST FIRST MIDDLE DATE

The thoroughness of this medical history is designed for your safety, and your complete answers will assist us in treating you with consideration for your special needs. This information will be considered confidential.

Family Physician ______________________ Date of last visit __________

Specialty ______________________

Address ______________________

Number Street City Sate Zip Code (Area Code) Phone

Other Physician ______________________ Date of last visit __________

Specialty ______________________

Address ______________________

Number Street City Sate Zip Code (Area Code) Phone

Please Circle YES or NO.

1. Are you in poor health? .... YES NO
2. Are you currently under the care of a physician? .... YES NO
   If so, what is the condition being treated? ....
3. Have you been hospitalized or had any serious illness in the past 5 years? .... YES NO
   If so, for what condition? ....
4. Do you have heart trouble or any form of cardiovascular disease? .... YES NO
   - ☐ 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
   - ☐ Other __________
5. Do you have or have you had any blood disease? .... YES NO
   - ☐ Excessive bleeding
   - ☐ Venereal Disease
   - ☐ Other
   - ☐ AIDS or positive test
   - ☐ AIDS Related Complex (ARC)
   - ☐ Leukemia
   - ☐ Anemia
6. Do you have, or have you had any of the following?
   - Diabetes? .... YES NO
   - Hypoglycemia? .... YES NO
   - Kidney Disease? .... YES NO
   - Glaucoma? .... YES NO
   - Stomach Ulcer? .... YES NO
   - Intestinal Ulcer? .... YES NO
   - Tuberculosis? .... YES NO
   - Hepatitis? .... YES NO
     - ☐ Type A Infectious (food)
     - ☐ Type B Serum (blood)
     - ☐ Other __________
   - Emphysema, Asthma or breathing problem? .... YES NO
   - Arthritis (Rheumatoid, Osteoarthritis)? .... YES NO
   - Hip or joint replacement? .... YES NO
   - Liver disease or Jaundice? .... YES NO
   - Fainting spells, convulsions, epilepsy? .... YES NO
   - Surgery, radiation, or other treatment for cancer? .... YES NO
   - Injury or pain from your jaw joint (TMJ)? .... YES NO
   - Chronic head, neck or back pain problems? .... YES NO
   - Trauma to your head or neck? .... YES NO

7. (Women) Are you pregnant? (Expected delivery date____________) .... YES NO

8. (Women) Do you have a history of previous miscarriages? .... YES NO

9. (Women) Are you taking birth control pills? *(Antibiotics may nullify effective contraception)* .... YES NO

10. Are you allergic to, or have had any unusual reaction to any of the following medications? .... YES NO

- ☐ Penicillin
- ☐ Erythromycin
- ☐ Sulfa Drugs
- ☐ Other antibiotics ____________
- ☐ Codeine
- ☐ Aspirin
- ☐ Other pain medications
- ☐ Local Anesthetics
  - ☐ Novacaine
  - ☐ Xylocaine
- ☐ Epinephrine
- ☐ Barbiturates
- ☐ Sleeping pills
- ☐ Any other drugs? ____________

11. Any other allergies or hives?________________________ Sinus trouble ________________________

12. Have you ever been advised not to take a particular medication? .... YES NO

If yes, please list ________________________________

13. Have you ever been advised to take antibiotics before dental treatment? .... YES NO

14. Please indicate if you are taking any of the following medications?

- ☐ Heart Medication
- ☐ Blood Pressure Medication
- ☐ Nitroglycerine
- ☐ Inderal
- ☐ Antibiotics
- ☐ Sedatives
- ☐ Tranquilizers
- ☐ Pain Medication
- ☐ Cortisone (Steroids)
- ☐ Thyroid
- ☐ Other Medications
- ☐ Alcohol (________) drinks per day
- ☐ "Recreational" drugs such as cocaine, marijuana, stimulants or depressants

Name	Purpose	Frequency

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.

Signature____ Date ______________