

Medical History

Patient Name:
 Last First MI Preferred Name

Indicate which of the following conditions you have experienced. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergy, Codeine | <input type="checkbox"/> Allergy, Latex | <input type="checkbox"/> Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artif.Heart Valve | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Clotting Disor | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Growths | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B/C |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> MVP | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Premedicate | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease |

- | | |
|---|--|
| <input type="checkbox"/> Ever been hospitalized (illness or injury) | <input type="checkbox"/> Presently being treated for any other illnesses |
| <input type="checkbox"/> Subject to frequent headaches | <input type="checkbox"/> Tobacco/Alcohol Use |
| <input type="checkbox"/> FEMALE: Taking birth control pills | <input type="checkbox"/> FEMALE: Pregnant |

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

What is your estimate of your general health?

- Excellent
 Good
 Fair
 Poor

Name of your physician and phone number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications (prescription and non-prescription) including regular doses of aspirin:

Do you have any medication allergies? If yes, please list.

* By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Response Date: