

Medical History

Certain illnesses and medications may make it necessary for us to alter your dental treatment. In our endeavor to provide you with the most appropriate health care, it is necessary to collect the following information about your health. Please indicate by checking yes or no for all descriptions that are part of your medical profile. Please be assured that this document will be treated with the utmost confidentiality.

Patient name:

Conditions			Premedication Required by MD	Yes	No
Abdominal Bleeding	Yes	No	Respiratory Problems	Yes	No
Allergy Problems	Yes	No	Radiation Therapy	Yes	No
Anemia	Yes	No	Rheumatic Fever	Yes	No
Arthritis	Yes	No	Shortness of Breath	Yes	No
Artificial Heart Valve	Yes	No	Sinus Problems	Yes	No
Asthma	Yes	No	Skin Rashes	Yes	No
Back or Neck Pain	Yes	No	Stroke	Yes	No
Blood Pressure Problems	Yes	No	Taken Fen-Phen	Yes	No
Blood Disorders	Yes	No	Thyroid Problems	Yes	No
Blood Transfusion	Yes	No	Tuberculosis	Yes	No
Bone or Joint Problems	Yes	No	Ulcers	Yes	No
For Women					
Bruise Easily	Yes	No	Are you using birth control pills?	Yes	No
Cancer / Tumor	Yes	No	Are you pregnant?	Yes	No
Chest Pain	Yes	No	Are you nursing?	Yes	No
Cosmetic Surgery	Yes	No	Medication Allergies		
Diabetes	Yes	No	Aspirin	Yes	No
Emphysema	Yes	No	Codeine	Yes	No
Epilepsy or Seizures	Yes	No	Dental Anesthetics	Yes	No
Fainting Spells	Yes	No	Erythromycin	Yes	No
Fever Blisters	Yes	No	Penicillin	Yes	No
Frequent Nosebleeds	Yes	No	Sulfa	Yes	No
Frequent or Severe Headaches	Yes	No	Tetracycline	Yes	No
Glaucoma	Yes	No	Other Allergies		
HIV-Positive / AIDS	Yes	No	Jewelry	Yes	No
Hay Fever	Yes	No	Metals	Yes	No
Heart Murmur	Yes	No	Latex	Yes	No
Heart Problems	Yes	No	Other (specify on next page):	Yes	No
Heart Valve Problems	Yes	No	Other Information		
Hemophilia	Yes	No	Do you use tobacco products?	Yes	No
Hepatitis, Jaundice, Liver Problems	Yes	No	Do you drink alcohol?	Yes	No
Herpes or Other STD	Yes	No	History of alcohol abuse?	Yes	No
Joint Replacement	Yes	No	Are you on a special diet?	Yes	No
Kidney or Bladder Problem	Yes	No	If so, describe:		
Pacemaker	Yes	No			

Pursuant to the Health Care Portability & Accountability Act of 1996 this is a proprietary document that contains protected health information (PHI). This document may not be viewed by persons for whom the information appearing herein is not legitimate job related information associated with rendering health treatment or appropriate administrative support to the patient.

Primary care physician:

Name	Phone number
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Have you ever been hospitalized?

YES

NO

If you've been hospitalized, please describe when and purpose:

Please list all medications you are taking:

Please list all other allergies not specified on first page:

Dental History:

Are you apprehensive about going to the dentist?	Yes	No
Are you satisfied with color of your teeth?	Yes	No
Do you have any broken or chipped teeth?	Yes	No
Do you have dental pain?	Yes	No
Are your teeth crowded?	Yes	No
How often do you brush?		
How often do you floss?		

Additional information you would like us to know:

Signed: _____
Patient signature

Date signed: _____

Signed: _____
Doctor signature

Date signed: _____