



Medical History

Patient Name: _____

Date of Birth: _____

Check (✓) which answer best applies to you:

Do you have good overall health? Yes No

Has there been a change in your health history within the last year? Yes No

Have you been hospitalized for a serious illness or surgery within the last three (3) years? Yes No
If Yes, why? _____

Are you currently under the care of a Physician? Yes No
Why? _____

Are you currently taking any medications? If Yes, please list: Yes No
Medication Condition Prescribing Physician

Have you been told by a Physician to Pre-Medicate before dental treatment? Yes No

Have you had any adverse reactions to any medications or drugs? Yes No
If so, please list: _____

Are you currently using: Yes No
Recreational Drugs? Yes No
Tobacco, in any form? Yes No
Alcohol? Yes No

Have you experienced complications with previous dental treatment? Yes No

Are you in pain now? Yes No

Women: Are you pregnant? Yes No Nursing? Yes No Taking Contraceptives? Yes No

Check (✓) if you have or have had problems with any of the following:

- | | | | | | |
|-----------------|----------------------------------------------------------|-------------------------------|----------------------------------------------------------|---------------------|----------------------------------------------------------|
| Recent Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Persistent Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ringing in Ears | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Coughing up Blood | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss/Gain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting Spell | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easy Bruising | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Vomiting/Nausea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diarrhea/Constipation/etc. | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest Pain (Angina) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Contact Lenses | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty/Frequent Urinating | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney/Bladder Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthetic Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Problems/Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain/Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiovascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes, Type____	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please Explain:	
Hepatitis, Type____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid, Adrenal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you have or have you had any other diseases or medical problems **NOT** listed above? Yes No
 If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I understand it is my responsibility to inform my doctor of any change in my health and/or medications.

Patient's Signature: _____

Date: _____