MEDICAL HISTORY

(1) How would you classify your General Health (circle one)? **Excellent** **Good** **Fair** **Poor**

(2) Are you presently under the care of a physician? If yes, for what? ______________________________

(3) Personal Physician __________________________Address/Phone ______________________________

Accurate and complete disclosure of medical information is necessary for proper diagnosis and to help prevent unnecessary complications during your treatment. PLEASE CHECK THE APPROPRIATE BOX for any conditions that you have now or had in the past.
(Parent/Guardian: Please check the appropriate boxes concerning your child's health status)

Cardiovascular (Heart)	Yes	No
High Blood Pressure		
Heart Attack		
If so When? ______________		
Angina/Chest Pain		
Take Blood Thinner		
Take Daily Aspirin		
Artificial Cardiac Valves		
Previous Infective Endocarditis ☐		
Congenital Heart Defect		
Mitral Valve Prolapse		
Rheumatic Fever		
Heart Murmur		
Irregular Heart Beat		
Heart Pacemaker		
Heart Surgery		
If so, when? ___________		
Other Heart Problems		
What, ________________		

Have you been instructed to premedicate with antibiotics prior to all dental treatment for any health related conditions (such as Artificial Valves, Artificial Joints, Previous Heart Infection, etc…)?
Yes ☐ **No** ☐

Nerves & Sensory	Yes	No
Severe Headaches		
Fainting / Dizzy Spells		
Epilepsy / Seizures		
Nervousness		
Dental Anxiety		

Respiratory (Breathing)		
Sinus Problems		
Allergies or Hives		
Asthma		
Use inhaler? __________		
Tuberculosis (TB)		

Dermal/Musculoskeletal		
Allergy to Latex		
Joint Replacement		
Sore Jaw Muscles / Joints		
Arthritis		
Mouth Ulcers / Sores		

Gastrointestinal (Stomach)		
Ulcers		
Liver Disease/Failure		
Hepatitis		
When? Type? _______________		

Endocrine (Hormonal)	Yes	No
Diabetes		
Take Insulin? _________		
Thyroid Disease		

Hematologic (Blood)		
Stroke		
If so, when? __________		
Anemia		
Prolonged Bleeding		
Leukemia		
HIV / AIDS Positive		

Urinary		
Kidney Disease/Failure		

Other Conditions		
Use Tobacco		
Drug Dependency		
Tumor / Cancer		
Radiation / Chemotherapy		
Immunosuppression		
Organ Transplant		

Have you ever taken medication for **Osteoporosis/Bone Disease** to increase bone density (i.e. **Fosamax, Boniva, Actonel, Aredia, Zometa, Reclast**) **Yes** ☐ **No** ☐

Are you taking (or supposed to be taking) any medicine, drugs or pills of any kind (including Aspirin / non-prescription drugs)?
Yes ☐ **No** ☐ If so, what?

Are you allergic to any drugs or medicines (**Including anesthetic**)? **Yes** ☐ **No** ☐ If so, what drug?/What type of reaction did you have?

Please list any other medical conditions or concerns not mentioned above that the Doctor should be aware of:

WOMEN: Are you pregnant? **Yes** ☐ **No** ☐ How long (circle one)? **1-3 months** **3-6 months** **6-9 months**

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change, I will inform the dentist at the next appointment.

______________ ______________________________________

Date Patient, Parent or Guardian Signature