MEDICAL HISTORY

Circle any of the following which you have had or have at the present

❑Heart Failure
❑High Blood Pressure
❑Rheumatic Fever
❑Mitral Valve Prolapse
❑Swollen Ankles
❑Shortness of Breath
❑Persistent Cough
❑Sinus Trouble
❑Radiation Treatment
❑Cortisone or Steroid ❑Medicine
❑AIDS/HIV
❑Yellow Jaundice
❑Hemophilia
❑Fainting or Dizzy Spells
❑Sickle Cell Disease
❑Swollen Glands

❑Anemia
❑Blood in your stool
❑Blood in Urine
❑Diabetes
❑Heart Disease or Attack
❑Stroke
❑Scarlet Fever
❑Heart Pacemaker
❑Chest Pains
❑Emphysema
❑Tuberculosis (TB)
❑Thyroid Disease
❑Chemotherapy
❑Glaucoma
❑Hepatitis
❑Blood Transfusion

❑Venereal Disease (Syphilis, Gonorrhea)
❑Nervousness
❑Bruise Easily
❑Unexplained Gain or Loss of Weight
❑Night Sweats
❑Ulcers
❑Kidney Trouble
❑Increase in Thirst
❑Angina Pectoris
❑Heart Murmur
❑Artificial Heart Valve
❑Heart Surgery
❑Artificial Joint
❑Chronic Bronchitis

❑Asthma
❑Any Form of Cancer
❑Arthritis
❑Food Allergies
❑Liver Disease
❑Drug or Alcohol Abuse
❑Epilepsy or Seizures
❑Psychiatric Treatment
❑Chronic Diarrhea or Constipation
❑Recent Fever
❑Frequent Infections
❑Frequent Vomiting
❑Difficulty Urinating
❑Frequent Urination

Do You Have Any of the Following Drug Allergies?

❑ Y ❑ N Aspirin ❑ Y ❑ N Codeine

❑ Y ❑ N Nitrous Oxide ❑ Y ❑ N Penicillin

❑ Y ❑ N Other _____

Family Physician _____

Phone (____) _____-_____

Are you under a physicians' care? What for? _____

_____

Are you taking any medications? What? Please include herbal supplements: _____

_____

_____

❑ Y ❑ N Have you ever had a general anesthetic? ❑ Y ❑ N Have you ever been admitted to a hospital? _____

❑ Y ❑ N Have you ever had a bleeding problem following any type of surgery or tooth extractions?
If yes, please explain: _____

❑ Y ❑ N Do you smoke? If yes, how much? _____

❑ Y ❑ N Do you drink alcoholic beverages?

❑ Y ❑ N Are you Pregnant? Obstetrician _____

❑ Y ❑ N Have you ever had a drug dependency problem?
If yes, please explain: _____

❑ Y ❑ N Do you use recreational drugs?

❑ Y ❑ N Do you have difficulty opening your mouth?

❑ Y ❑ N Do you have pain or noise in your jaw joints?

❑ Y ❑ N Do you have pain in your temples or cheeks?

❑ Y ❑ N Do you have pain chewing or yawning?

❑ Y ❑ N Do you clinch or grind your teeth?

❑ Y ❑ N Have you ever been treated for TMJ problems?

Approximate date of last medical exam? _____/_____/_____

Is there any other medical or dental information we should know about? _____

Notice to Patients Taking Oral Contraceptives (Birth Control Pills)

The effectiveness of birth control pills can be reduced by taking or using some drugs used in dental surgery. These drugs include pain medication, antibiotics and drugs used in sedation and anesthesia.

This is to inform you of this possibility and when indicated, other forms of birth control should be used during the month that oral surgery is performed. _____ (please initial)

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

Date _____/_____/_____ Signature of Patient, Parent or Guardian _____