Patient Medical History **Name:** **Date:**

□ Yes □ No □ Unknown 1. Are you under the care of a physician for a current problem? If yes, please explain.

□ Yes □ No □ Unknown 2. Have you been hospitalized within the past 5 years? If yes, please explain.

□ Yes □ No □ Unknown 3. Have you received therapy for alcoholism or drug addiction during the past 5 years?

□ Yes □ No □ Unknown 4. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/medications?

□ Yes □ No □ Unknown 5. Is there any condition concerning your health that the doctor should be told? If yes, please explain.

□ Yes □ No □ Unknown 6. Have you had abnormal bleeding with previous extractions, surgery, or trauma?

□ Yes □ No □ Unknown 7. Have you ever required a blood transfusion?

□ Yes □ No □ Unknown 8. Are you required to take antibiotics prior to dental treatment?

9. Do you have, or have you had, any of the following:

□ high blood pressure

□ low blood pressure

□ heart murmur or prolapsed valve

□ joint replacement (hip, knee, etc.)

□ rheumatic fever or rheumatic heart disease

□ congenital heart disease

□ cardiovascular disease: heart attack, stroke, or bypass

□ prosthetic heart valve

□ blood disorder (ex. Anemia)

□ venereal disease

□ asthma

□ allergy to latex

□ chest pain, angina

□ swollen ankles, arthritis, or joint disease

□ cardiac pacemaker

□ heart surgery

□ delay in healing

□ tuberculosis

□ emphysema

□ X-ray treatment or chemotherapy

□ HIV or AIDS

□ eye disease or glaucoma

□ infectious mononucleosis

□ sinus trouble

□ thyroid problems

□ diabetes

□ stomach ulcers, colitis

□ hepatitis, jaundice, liver disease

□ kidney problems

□ psychiatric treatment

□ fainting spells or seizures

□ epilepsy

□ cancer

□ temporomandibular joint problems (TMJ)

□ low blood sugar

□ dialysis

□ irregular heart beat

□ contagious diseases

□ bronchitis, severe cough

□ hay fever or sinus problems

□ problems with immune system

□ difficulty breathing or other lung problem

□ chronic fatigue or night sweats

□ wear contact lenses

□ bruise easily

□ gallbladder trouble

□ Yes □ No □ Unknown	10. Do you have any disease, condition, or problem not listed above? If yes, please explain,
□ Yes □ No □ Unknown	11. Are you taking bisphosphonates now or have you ever taken them in the past (Fosamax)?
□ Yes □ No □ Unknown	12. Are you taking any medication or drugs? If yes, please list below.

Women only: 13. Are you:

□ pregnant □ breastfeeding □ taking birth control pills □ n/a

I certify that I have read and understood the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for actions they take or do not take because of errors or omissions that I may have made in completing and updating this form.

Signature: ____ Date: ________________