Name _____

Birth date _____

BP: Pulse:

Medical History

Physician's Name_____ Physician's Telephone_____

Physician's Address _____

Date of last physical exam _____

1. Do you have a specific **medical** condition that you want to discuss?.....Yes No
2. Are you under a physician's care or have you been hospitalized recently?.....Yes No
3. Have you had any surgeries or operations? Specify _____
4. Are you taking medication?.....Yes No
   - ☐ blood thinners ☐ steroids ☐ nitroglycerin ☐ bisphosphonates
   - ☐ other Please specify:_____
5. Have you ever had heart problems, heart murmur or rheumatic fever?.....Yes No
6. Have you ever had a joint replacement?.....Yes No
7. Have you ever had head or neck surgery or radiation therapy?.....Yes No
8. Have you ever been told you need to take antibiotic premedication before dental treatment?.....Yes No
9. Have you ever had excessive bleeding after tooth extractions or cuts? .....Yes No
10. Have you ever had **high** or **low** blood pressure? (if yes, circle one).....Yes No
11. Do you have epilepsy, or ever feel faint, dizzy, or have seizures?.....Yes No
12. Are you allergic to:.....Yes No
    - ☐ penicillin ☐ other antibiotics ☐ aspirin ☐ ibuprofen ☐ latex
    - ☐ sulfa antibiotics ☐ anesthetics ☐ other drugs Please specify below:

    _____
13. Have you ever received positive test results for:. .....Yes No
    - ☐ tuberculosis ☐ hepatitis ☐ HIV or AIDS
14. Have you ever had any of the following: .....Yes No
    - ☐ diabetes Type I ☐ bleeding problems ☐ loss of hearing ☐ cold sores
    - ☐ diabetes Type II ☐ high cholesterol ☐ speech impairment ☐ sexually transmitted diseases
    - ☐ thyroid problems ☐ leukemia ☐ eyesight problems
    - ☐ liver problems ☐ cancer ☐ mental illness ☐ arthritis
    - ☐ kidney problems ☐ asthma ☐ mental retardation ☐ birth defect
    - ☐ stomach ulcers ☐ hay fever/bronchitis ☐ cerebral palsy ☐ pacemaker
    - ☐ Other conditions not specified above _____
15. Have you ever been vaccinated for hepatitis B?.....Yes No
16. Do you : ☐ smoke ☐ drink alcohol ☐ use recreational drugs
17. Are you a recovering alcoholic or drug abuser?. .....Yes No
18. **Women**: Are you : ☐ pregnant ☐ taking birth control pills

Comments / Medications

Update Information (Office Use Only)

Date	*Comments*	*Initials*	*Date*	*Comments*	*Initials*