PATIENT MEDICAL HISTORY

Please print legibly

PATIENT NAME _____

ADDRESS _____

PATIENT HOME # _____ WORK _____

	Yes	No	Don't Know
1. Do you have unhealed injuries or inflamed area, growths or sore spots in or around your mouth?			
2. Has there been any change in your general health within the past year? If yes, please explain.			
3. Are you under the care of a physician for a current problem? If yes, please explain			
4. Have you been hospitalized within the past 5 years?			
5. Are you taking any medication or drugs? Please list them below.			
6. Have you received therapy for alcoholism or drug addiction during the past 5 years?			
7. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/medications?			
8. Is there any condition concerning your health that the doctor should be told about?			
9. Have you had abnormal bleeding with previous extractions, surgery, or trauma?			
10. Have you ever required a blood transfusion?			
11. Have you ever had surgery and / or radiation for a tumor, growth, or other condition?			
12. Have you ever tested positively for HIV infection or AIDS?			
13. Are you required to take antibiotics prior to dental treatment?			
14. WOMAN ONLY: Are you pregnant, nursing, or on birth control pills?			
15. Are you generally pleased with the appearance of your teeth?			

Do you have any of the following?

	High blood Pressure		Sinus trouble
	Heart murmur or prolapsed valve		Thyroid problems
	Joint prosthesis (hip ,knee, etc.)		Diabetes
	Rheumatic fever or rheumatic heart disease		Stomach ulcers, colitis
	Congenital heart disease		Hepatitis, jaundice, liver disease
	Cardiovascular disease: heart attack, stroke or bypass		Psychiatric treatment
	Prosthetic heart valve		Fainting spells or seizures
	Blood disorder (e.g. anemia)		Epilepsy
	Venereal disease		Cancer
	Asthma		Temporomandibular joint problems (TMJ)
	Allergy to latex		Low blood sugar
	Low blood pressure		Dialysis
	Chest pain, angina		Irregular heart beat
	Contagious diseases		Problems with immune system
	Heart surgery		Bronchitis, chronic cough
	Difficult breathing or other lung trouble		Tuberculosis
	Emphysema		Chronic fatigue or night sweats
	X-Ray treatment or chemotherapy		None of the above

_____ _____

Patient Signature (Patient, or patient of minor). Date