MEDICAL HEALTH HISTORY

Name_____ SS # _____

Birthdate_____ Sex F M

Your comfort and good oral health are dependent on accurate knowledge of your medical condition. Many medical situations affect or are affected by procedures and/or drugs used for dentistry. Please, fill out the following conscientiously by circling the appropriate answers. Your answers will be held confidential according to our privacy practices.

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

Hepatitis (Jaundice)……	YES	NO	High Blood Pressure……	YES	NO
Rheumatic Fever……	YES	NO	Low Blood Pressure……	YES	NO
Diabetes……	YES	NO	Stomach Ulcer……	YES	NO
Thyroid Condition……	YES	NO	Alcoholism/Drug Abuse…..	YES	NO
Malignancy (Tumor)……	YES	NO	Epilepsy (Seizures)……	YES	NO
Chronic Sinus Problems……	YES	NO	Psychiatric Care……	YES	NO
Fainting or Dizziness……	YES	NO	Kidney Disease……	YES	NO
Heart Attack……	YES	NO	Asthma……	YES	NO
Chest Pain……	YES	NO	Herpes or other STD…….	YES	NO
Stroke……	YES	NO	HIV positive/AIDS……	YES	NO

HAVE YOU EXPERIENCED AN UNUSUAL REACTION TO ANY OF THE FOLLOWING MEDICATIONS?

Penicillin……	YES	NO	Aspirin……	YES	NO
Dental Anesthetic……	YES	NO	Any other drug……	YES	NO

HAVE YOU BEEN TOLD BY YOUR DOCTOR YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

Infective Endocarditis……	YES	NO	Congenital Heart Disease….	YES	NO
Any Heart Condition……	YES	NO			

HAVE YOU HAD ANY OF THE FOLLOWING PROSTHETIC SURGERIES?

Prosthetic Heart Valve……	YES	NO	Artificial Hip……	YES	NO
Joint Replacement……	YES	NO	Organ Transplant……	YES	NO

ARE YOU NOW OR HAVE BEEN WITHIN THE LAST YEAR?

Seeing a Physician……	YES	NO	Pregnant……	YES	NO
Taking any Medications……	YES	NO	Taking Meds for your Bones…	YES	NO

Please, list your current medications:_____

_____

TO MY KNOWLEDGE THE ANSWERS I HAVE GIVEN ON THIS PAGE ARE TRUE. Patient/Guardian Signature_____

Date_____

_Doctor's notes_____