MEDICAL HISTORY

Please answer the following:

Patient Name: _____

Height_____ Weight_____

M F Sex: □ □

Y N □ □ Do you smoke or use tobacco?

Please mark Y (yes) or N (no) to all of the following:

Y N	Conditions	Y N	Conditions	Y N	Conditions
□ □	Abnormal Bleeding	□ □	Heart Attack	□ □	Stroke
□ □	Alcohol Abuse	□ □	Heart Murmur	□ □	Taken Fen-Phen
□ □	Anemia	□ □	Heart Surgery	□ □	Thyroid Problems
□ □	Angina Pectoris	□ □	Hemophilia	□ □	Tuberculosis
□ □	Arthritis	□ □	Hepatitis A	□ □	Ulcers
□ □	Artificial Bones	□ □	Hepatitis B	□ □	Venereal Disease
□ □	Artificial Heart Valve	□ □	Hepatitis C		
□ □	Artificial Joints/Pins	□ □	High Blood Pressure	Y N	**Allergies**
□ □	Asthma	□ □	Human Papilloma Virus	□ □	Aspirin
□ □	Blood Transfusion	□ □	Kidney Problems	□ □	Bananas
□ □	Cancer-Chemotherapy	□ □	Liver Disease	□ □	Codeine
□ □	Congenital Heart Defect	□ □	Low Blood Pressure	□ □	Dental Anesthetics
□ □	Diabetes	□ □	Mitral Valve Prolapse	□ □	Erythromycin
□ □	Difficulty Breathing	□ □	Pace Maker	□ □	Iodine
□ □	Drug Abuse	□ □	Pain In Jaw Joints	□ □	Jewelry
□ □	Emphysema	□ □	Pneumocystitis	□ □	Latex
□ □	Epilepsy	□ □	Psychiatric Problems	□ □	Lactose
□ □	Fainting Spells	□ □	Radiation Therapy	□ □	Metals
□ □	Fever Blisters	□ □	Rheumatic Fever	□ □	Nuts
□ □	Frequent Headaches	□ □	Seizures	□ □	Penicillin
□ □	Glaucoma	□ □	Shingles	□ □	Sulfa
□ □	Hay Fever	□ □	Sickle Cell Disease	□ □	Tetracycline
□ □	HIV+ AIDS	□ □	Sinus Problems		

Medications Used: (Please List)

_____

Y N

□ □ Have you ever been told you need to pre-medicate with antibiotics before a dental appointment?

□ □ Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe: _____

□ □ Do you brush your teeth two or more times per day?

□ □ Do you floss everyday?

□ □ Do you frequently consume food high in sugars?

□ □ Are you currently taking blood thinners?

□ □ Do you frequently have "dry mouth"?

□ □ Are your teeth sensitive to hot, cold or certain foods?

□ □ Are you undergoing chemotherapy or radiation treatments?

□ □ Have you ever been treated for gum disease?

□ □ Do your gums ever bleed?

□ □ Date of last cleaning? _____

Patient/Parent's Signature: _____ Date: _____