CONFIDENTIAL MEDICAL HISTORY

Patient Name _____ Birth Date ___/___/___

Emergency Contact: _____ Phone ( ) _____

Physician's Name _____ Phone ( ) _____ Last Exam ___/___/___

Are you currently under a physician's care? ☐ Yes ☐ No If yes, describe _____

Do you currently take or have you taken **pre-medication** prior to a dental visit? ☐ Yes ☐ No Type _____

Do you use **Tobacco**? ☐ Yes ☐ No If yes, what kind _____

Women: Are you taking birth control pills? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No Due date: ___/___/___

Check ( ) if you currently have or have had any of the following:

Cardiovascular Conditions

YES	NO	
☐	☐	Rheumatic fever, Rheumatic heart disease
☐	☐	Heart Murmur
☐	☐	Congenital heart defect
☐	☐	Vascular disease
☐	☐	Heart surgery/Angioplasty
☐	☐	Infective endocarditis
☐	☐	Mitral valve prolapse
☐	☐	Pacemaker
☐	☐	Prosthetic heart valve
☐	☐	High blood pressure
☐	☐	Stroke
☐	☐	Heart attack
☐	☐	Angina
☐	☐	Heart transplant
☐	☐	Blood transfusion
☐	☐	Hemophilia, other bleeding disorder

YES	NO	
☐	☐	Liver disease, jaundice
☐	☐	Hepatitis: Type _____
☐	☐	Liver transplant
☐	☐	Diabetes mellitus
☐	☐	Kidney trouble, dialysis or transplant
☐	☐	Thyroid problems
☐	☐	Lupus
☐	☐	Asthma
☐	☐	Arthritis, rheumatism
☐	☐	Orthopedic pins, rods, screws
☐	☐	Joint replacement
☐	☐	Prosthetic devices or implants: Type: _____
☐	☐	Anemia
☐	☐	Leukemia
☐	☐	Tuberculosis

Other Conditions

YES	NO	
☐	☐	HIV-infection/AIDS
☐	☐	Stomach ulcers
☐	☐	Glaucoma
☐	☐	Chemical dependency
☐	☐	Emotional, mental or nervous disorders
		Eating disorders:
☐	☐	Bulimia &/or Anorexia Nervosa
		Ankle swelling
☐	☐	Extreme thirst
☐	☐	Extreme dry mouth
☐	☐	Unusual weight loss or gain
☐	☐	Abnormal bleeding (after tooth extraction, surgery, etc.)
		Bruise easily
☐	☐	Cancer: Type _____
☐	☐	Radiation or Chemotherapy

Other conditions or problems not listed above that we should know about:

_____

_____

Medications

Please list below, or on a separate sheet, all medications you are currently taking, including birth control:

Medications	Reason

Allergies

Are you allergic to, or have you had any reactions to:

Local Anesthetic (Novocain)? ☐ Yes ☐ No

Penicillin, or other antibiotics? ☐ Yes ☐ No

Aspirin or other medications? ☐ Yes ☐ No

Other: _____

___/___/___

↑ SIGNATURE OF PATIENT, PARENT, OR GUARDIAN ↑ DATE

MEDICAL REVIEW: I HAVE REVIEWED THIS MEDICAL HISTORY AND HAVE ADDED ANY CHANGES SINCE MY LAST VISIT:

DATE & INITIAL: _____

DATE & INITIAL: _____

DATE & INITIAL: _____

DATE & INITIAL: _____

DATE & INITIAL: _____