

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: _____

Have you ever had a **blood transfusion**? Yes No If yes, give approximate dates _____

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

Have you ever taken **Fen-Phen** or **Redux**? Yes No

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

- 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
- Other: _____

Other Conditions

- Liver disease, jaundice
- Hepatitis
- 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
- Hemophilia, other bleeding disorder
- Tuberculosis
- 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:

Allergies

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

- Local Anesthetic (Novocaine)? 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: _____	DATE & INITIAL: _____
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