MEDICAL HISTORY

Date _____

Patient Name _____ Preferred Name _____ Age _____

Name of Physician _____ Most recent physical exam _____

Reason _____

Circle an estimate of your general health: Excellent Good Fair Poor

Have you ever had an allergic reaction to:

Clindamycin	Yes	No		Codeine	Yes	No
Erythromycin	Yes	No		Ibuprofen	Yes	No
Latex	Yes	No		Penicillin	Yes	No
Sulfa	Yes	No		Tetracycline	Yes	No
Tramadol	Yes	No		Tylenol	Yes	No

Other _____

Please check yes or no to the following questions. Note the date if any answer is yes.

No	Yes	Date	
____	____	_____	Hospitalization for illness or injury in the last 2 years?
____	____	_____	Heart problems, or surgery, within the last 6 months?
____	____	_____	Can you walk up a flight of stairs without having to stop and rest, or getting short of breath?
____	____	_____	History of uneffective endocarditis?
____	____	_____	Artificial heart valve or repaired heart defect (PFO)?
____	____	_____	Pacemaker or implantable defibrillator?
____	____	_____	Artificial prosthesis (heart valve, joints, hip or knee replacement)?
____	____	_____	High blood pressure?
____	____	_____	Low blood pressure?
____	____	_____	Stroke?
____	____	_____	COPD?
____	____	_____	Tuberculosis?
____	____	_____	Asthma?
____	____	_____	High cholesterol or taking statin drugs?
____	____	_____	Diabetes Type 1?
____	____	_____	Diabetes Type 2?
____	____	_____	Are you taking anything for Osteoporosis (soft bones, i.e. bisphosphonates)?
____	____	_____	Is it uncomfortable for you to sit in a dental chair in a laid-back position?
____	____	_____	Epilepsy or convulsions?
____	____	_____	Hepatitis Type A, B, C, D, or E (please circle if applicable)?
____	____	_____	Blood thinners?
____	____	_____	Kidney disease?
____	____	_____	Liver disease?
____	____	_____	Dizziness/history of fainting?
____	____	_____	HIV/AIDS?
____	____	_____	Have you undergone chemotherapy or radiation therapy?
____	____	_____	Smoker, previous smoker, or use smokeless tobacco?
____	____	_____	Pregnant?

Do you have any health issues that we need to discuss, or could possibly affect your dental treatment? If yes, please explain.

_____

Please legibly list all medications, supplements, and/or vitamins taken within the last 2 years (or provide a list to the office):

_____

_____

Patient Signature _____ Doctor Signature _____ Date _____