PATIENT NAME

EMERGENCY CONTACT

MEDICAL HISTORY

1. Please give the name of your regular physician: _____ Phone: (____)_____

   Address _____

2. Are you under the care of any other physician(s) or specialists at this time? Yes No If yes, please list the name of the physician and why you are under care:

   _____

3. Are you taking any medication, drugs or pills now? Yes No If yes, please list name and dosage:

   _____ _____

   _____ _____

   _____ _____

   _____ _____

4. Are you allergic to any of the following?

   ❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Acrylic ❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Other

   If yes, please explain reaction: _____

5. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	**Acid Reflux / Heartburn**	**Yes**	**No**	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	**Seasonal Allergies**	**Yes**	**No**	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

6. Do you have or have you had any disease, condition, or problem not listed? Yes No

   If yes, please list: _____

7. **Women.** Are you: **Pregnant**? Yes, ___Months No **Nursing**? Yes No **Taking birth control pills**? Yes No
8. Do you use tobacco products? Yes No ❑ Chew ❑ Smoke How many years have you been using?_____
9. Are you concerned about bad taste or breath? Yes No
10. Have you been advised to take antibiotic premed prior to dental tx artificial joint (in last 2 years) or heart valve replacement?

    Yes No Other _____
11. Have you had surgery recently or been hospitalized? Yes No Why _____
12. Have you had Botox or Dermal Fillers? Yes No
13. Are you interested in Botox or Dermal Fillers? Yes No

Notes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may realease such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature_____ Date_____

Dentist Signature_____ Date_____