

MEDICAL HISTORY

Name _____ Date _____ Age _____ Height _____ Weight _____

1) List your Allergies & Reaction: _____

2) Are you allergic to Latex? (Y) (N) Adhesive Tape? (Y) (N) Local Anesthesia? (Y) (N)

3) List ALL your Medications & Dosages: _____

4) Do you take Aspirin? (Y) (N) Coumadin? (Y) (N) Steroids? (Y) (N)

5) Do you need antibiotics before dental work? (i.e. For heart valve problem or implant) (Y) (N)

6) Check ALL medical problems below that you have experienced and physician following your care:

- | | |
|---|--|
| <input type="checkbox"/> Seizures / Stroke/ Fainting | <input type="checkbox"/> Thyroid Problems (Diagnosis: _____) |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Liver Disease/Hepatitis |
| <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Immune Disease (HIV) |
| <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Stomach Ulcers/Reflux Disease |
| <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> Intestinal Problems (Diagnosis: _____) |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Bladder/ Kidney Problems (Diagnosis: _____) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Chest Pain/ Angina | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart Attack (MI) | <input type="checkbox"/> Excessive Bleeding (from cuts,surgery,etc) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Abnormal Scarring, Keloids |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Breast Cancer/Cysts | <input type="checkbox"/> Anxiety Reactions |
| <input type="checkbox"/> Other (please specify) _____ | |

7) List Any Previous Surgical Procedures & Dates _____

8) Have you ever had a Blood Transfusion? (Y) (N)

9) List any problems with General Anesthesia or Sedatives _____

10) Do you have: Dental Caps? (Y)(N) Bridgework? (Y)(N) Dentures? (Y)(N) Partials? (Y)(N)

11) List your Daily consumption or the following:
Coffee/Tea _____ Alcohol _____ Tobacco _____ Street Drugs _____

12) Is there a Family History of: If Yes, list relationship to you
a. Skin Cancer? (Y)(N) _____ b. Breast Cancer? (Y)(N) _____
b. Heart Disease? (Y)(N) _____ d. Diabetes? (Y)(N) _____
e. Other _____

13) Please advise us of any other pertinent history that may assist us in your care: _____

Signature _____ Date _____

Relationship to Patient (if minor) _____