Medical History

Name: ______________________________

Please complete all items. Leave no blanks.

Have you ever had any of the following illnesses? Please check all that apply.

- Heart attack ❑
- Heart failure ❑
- Angina ❑
- Coronary Artery Disease ❑
- Arrhythmia ❑
- High Blood Pressure ❑
- Asthma ❑
- Emphysema/ COPD ❑
- Other lung disease ❑
- Diabetes ❑
- Kidney disease ❑
- Rheumatic fever ❑
- Ulcers ❑
- Epilepsy/ seizures ❑
- Anemia ❑
- Liver disease ❑
- HIV / AIDS ❑
- Prosthetic Joint(s) ❑
- Stroke ❑
- Thyroid disease ❑
- Arthritis ❑
- Hepatitis ❑

Circle: A B C D

Height: ____' ____"

Weight: ________Lbs.

List dates and reasons for all prior hospitalizations.

______________________ or None ❑

____

____

List and provide dates for all prior surgeries.

______________________ or None ❑

____

____

Do you take any medicines regularly? (If so please list. Include herbal, alternative, and non-prescription medications.)

______________________ or None ❑

____

____

	Yes	No
Have you been under the care of a physician in the last 5 years?	❑	❑
Are you allergic to any medications or foods? (Ex: Penicillin, codeine, sulfa, aspirin, Novocaine, latex, eggs, soy)	❑	❑
Are you taking, or have you ever taken, medication for osteoporosis, myeloma, breast cancer, or other bone disease? (Ex: Fosamax, Actonel, Boniva, Didronel, Aredia, Zometa, Reclast)	❑	❑
Have you ever been diagnosed with a heart murmur?	❑	❑
If yes, have you been instructed to take antibiotics prior to dental procedures?	❑	❑
Do you smoke, or use chewing tobacco?	❑	❑

If yes how much? ______________________

	Yes	No
Have you ever tested positive for HIV, Hepatitis, Tuberculosis, or other infectious disease?	❑	❑
Do you tend to bleed or bruise easily, or have a family history of bleeding disorders?	❑	❑
Do you suffer from chronic sinus or nasal problems?	❑	❑
Have you ever had a bad reaction to anesthesia, or do you have a family history of anesthesia problems?	❑	❑
Have you ever been diagnosed with jaw joint (TMJ) problems?	❑	❑
Do your jaw joints (TMJ) pop, click, or get stuck?	❑	❑
Have you had anything to eat or drink in the last 8 hours?	❑	❑
Do you use marijuana, cocaine, methamphetamine, heroin, or other "recreational" or "street" drugs?	❑	❑
Do you have any other disease, condition or problem not listed, or do you wish to speak with the doctor privately about anything?	❑	❑

Female Patients:

	Yes	No
Are you pregnant or suspect you may be pregnant?	❑	❑

If yes, how many weeks? ______________

Date of last menstrual period: ______________

	Yes	No
Are you taking birth control pills?	❑	❑
Are you aware that antibiotics may interfere with birth control pills?	❑	❑

To the best of my knowledge, all of the above is true and correct. I understand that a complete and accurate medical history is important for my own safety when undergoing any surgical procedure.

Signature ______________________________ Date______________

(Patient, Parent/Guardian if minor)

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