MEDICAL HISTORY FORM

Please take sufficient time to **CAREFULLY** and **COMPLETELY** fill out this form. It is very important and can directly affect the treatment that you receive in this office.

	Yes	No
1. Are you now, or have you been under a physician's care during the past 3 years?	☐	☐
2. Have you been in the hospital at any time during the past 3 years?	☐	☐
3. Do you have allergies or sensitivities to drugs SUCH AS, BUT NOT LIMITED TO Penicillin, Novocaine, Codeine, Aspirin, etc.? Latex?	☐	☐

4. **Please list *ALL* drugs or products to which you are allergic on the line below.**

_____

5. **Please list the names of *ALL* medications that you are currently taking.** Please include birth control pills, any "natural herbal medicines" and other "over-the counter" drugs. IF YOU ARE NOT TAKING ANY MEDICATION AT THIS TIME, PLEASE WRITE THE WORD "**NONE**" ON THE LINES BELOW.

_____

_____

	Yes	No
6. Have you recently been taking "blood-thinners" or aspirin?	☐	☐
7. Have you ever had any excessive bleeding requiring special treatment?	☐	☐
8. Are you subject to fainting, dizziness, nervous disorders, convulsions or epilepsy?	☐	☐
9. Have you ever had breathing difficulties, such as asthma, emphysema or tuberculosis?	☐	☐
10. Are you, or could you be pregnant? Nursing?	☐	☐
11. Do you smoke cigarettes or use tobacco products?	☐	☐
12. Is there any present or past history of drug or alcohol abuse? Eating disorders?	☐	☐
13. Do you snore or have you ever been diagnosed with sleep apnea?	☐	☐
14. Has any **physician - M.D. (not dentist)** ever told you to take antibiotics **prior** to <u>every</u> dental appointment?	☐	☐
15. Do you have problems with your jaw joint (TMJ)? - clicking, popping, pain, limitation of opening?	☐	☐
16. Are there any behavioral / psychiatric / developmental or learning problems / delays?	☐	☐
17. Have you had any complications following dental treatment?	☐	☐

Please check yes or no to any of the following problems that you have or have had in the past.

	Yes	No		Yes	No		Yes	No
Angina (chest pain)	☐	☐	Diabetes	☐	☐	Hepatitis / liver disease	☐	☐
Artificial heart valve	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Heart attack	☐	☐	Any form of cancer	☐	☐	AIDS / HIV	☐	☐
Irregular heart beat	☐	☐	Kidney problem	☐	☐	Sinus Problems	☐	☐
Pacemaker	☐	☐	Ulcers	☐	☐	Acid Reflux	☐	☐
Angioplasty/stent	☐	☐	Shortness of breath	☐	☐	Osteoporosis	☐	☐
Bypass Surgery	☐	☐	Artificial joint	☐	☐	Radiation Treatment	☐	☐
Any other heart trouble	☐	☐	Stroke / TIA	☐	☐	**Any medical condition not listed above**	☐	☐

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, legally responsible for any errors or omissions that I may have made in the completion of this medical history form.

Signature of Patient/Guardian _____ **Date:** _____