Office Use	Medical Alert	Premedication	Allergies	Anesthesia

Medical Information and Health History

Patient name ______________________________ Date of birth ______________

Are you in good health? Yes No

Are you now under the care of a physician? Yes No

If yes, for what condition(s) are you being treated?

____

Has a physician or a previous dentist recommended that you take antibiotics prior to dental treatment? Yes No

If yes, what antibiotic and dosage?

____

Have you had any serious illness or operation, or been hospitalized in the past 3 years? Yes No

If yes, what was the illness or problem?

____

____

Women only:

Are you pregnant? If yes, _____ months Yes No

Could you be pregnant? Yes No

Are you nursing? Yes No

Are you taking birth control pills? Yes No

Physician: Name ______________ Phone ______________ Address ______________

Physician: Name ______________ Phone ______________ Address ______________

Are you presently taking any medications or supplements? Yes No If yes, please list below.

Name of Medication or Supplement	Dosage and How Often Taken	Reason for Taking

Have you had an allergic or adverse reaction to any medication, anesthetic or other substance? Yes No If yes, please list below.

Name of Medication or Substance	Description of Reaction

Indicate which of the following diseases, conditions or problems you have had, or have not had, by checking "Yes" or "No" to each item.

	Yes	No		Yes	No		Yes	No
Angina	☐	☐	High blood pressure	☐	☐	AIDS or HIV infection	☐	☐
Arteriosclerosis	☐	☐	Low blood pressure	☐	☐	Hepatitis or liver disease	☐	☐
Artificial heart valves	☐	☐	Abnormal bleeding	☐	☐	Sexually transmitted disease	☐	☐
Cardiac stents	☐	☐	Anemia	☐	☐	Arthritis	☐	☐
Congenital heart defects	☐	☐	Blood transfusion	☐	☐	Total joint replacement	☐	☐
Congestive heart failure	☐	☐	Hemophilia	☐	☐	Epilepsy	☐	☐
Coronary artery disease	☐	☐	Stroke	☐	☐	Fainting spells or seizures	☐	☐
Damaged heart valves	☐	☐	Asthma	☐	☐	Severe headaches / migraines	☐	☐
Heart attack	☐	☐	Bronchitis or emphysema	☐	☐	Diabetes	☐	☐
Heart murmur	☐	☐	Hay fever / seasonal allergies	☐	☐	Gastrointestinal problems	☐	☐
Mitral valve prolapse	☐	☐	Tuberculosis	☐	☐	Kidney problems	☐	☐
Pacemaker	☐	☐	Sinus problems	☐	☐	Thyroid problems	☐	☐
Rheumatic heart disease / rheumatic fever	☐	☐	Dry mouth	☐	☐	Cancer / chemotherapy / radiation treatment	☐	☐
			Mouth sores or ulcers	☐	☐			

Do you have or have you had any disease, condition or problem not listed above? Yes No If yes, please explain ______________

____

____

I have read and understand the above form, and affirm that the information I have provided is complete and accurate to the best of my knowledge. The information on this form replaces any medical information I have previously provided this office. If I have any changes in my health, medical condition or medications, I will inform the doctor at the next appointment.

Signature of patient, parent or responsible party ______________________ Date ______________

Office Use	