

PATIENT NAME _____ DATE _____

Medical History

Have you had any of these conditions that may require a pre-medication prior to your dental appointment*:

Artificial Joint Yes No If yes, year _____ Rheumatic Heart Disease Yes No
Artificial Heart Valve Yes No Endocarditis Yes No

Have you ever taken a pre-medication prior to dental appointments? _____ If yes, what type: _____
*In the event you do not take a prescribed pre-medication, your appointment will be rescheduled.

Please indicate if you have or ever have had any of the following:

	YES	NO		YES	NO		YES	NO
Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Yr _____ Type _____			Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery/Stints	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problem	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Active Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Tumors/Growths	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Auto Immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>

Physicians Name _____ Phone# _____

Have you ever had any serious illness not listed above? _____ Explain _____

Have you been hospitalized or had a major operation in the last 5 years? _____

Have you ever had a serious injury to your head or neck? _____ Describe _____

Do you snore, been told you snore or been diagnosed with sleep apnea? _____

Women: Are you pregnant? _____ Nursing? _____

ALLERGIES: Are you allergic or had an adverse reaction to any of the following?

Latex Metal Acrylic Epinephrine Local Anesthetic Codeine Penicillin

Any allergies not listed above? _____

MEDICATIONS: Please list all medications, including over-the-counter if taken regularly:

Patient Signature: _____ Date: _____

Reviewed by Doctor: _____ Date: _____

History Review and Significant Findings: _____