

Dental Patient Medical History

Name: _____ Age: _____

Please read carefully and answer each question as accurately as possible.

1. What is your impression of your present health? _____

2. Date of last medical exam? _____

3. Physicians Name _____ Phone _____

4. Please draw a circle around any of the following which you had or have.

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|----------------------------|--------------------------|-------------------------|
| Heart Disease or Condition | Tuberculosis | Venereal Disease |
| Angina Pectoris | Diabetes | Drug Addiction |
| Frequent Chest Pains | Ulcers | Psychiatric Treatment |
| Artificial Heart Valve | Kidney Trouble | Cancer |
| Rheumatic Fever | Liver Disease | Radiation Therapy |
| Stroke | Epilepsy or Seizures | Chemotherapy |
| Unusual Bleeding | Fainting or Dizzy Spells | Unexplained Weight Loss |
| Asthma | Emphysema | Shortness of Breath |

**CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS. (If in doubt, circle Yes)
(If Yes, please give details.) CONTINUE COMMENTS ON BACK IF NECESSARY.**

5. Are you currently under care for any medical problems?	YES	NO
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6. Are you taking any medications or dietary supplements (i.e. vitamins)? If so please list type and dosages:	YES	NO
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7. Have you been tested for HIV? If so: Positive _____ Negative _____	YES	NO
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8. Are you currently or have you taken any medicine for bone diseases (i.e. Bone cancer, osteoporosis)?	YES	NO
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9. Are you allergic to any medicine?	YES	NO
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10. Do you have any artificial heart valves?	YES	NO
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11. Have you had hepatitis? If so, when? _____	YES	NO
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12. Do you have any artificial joints?	YES	NO
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13. Have you ever had a reaction to local anesthetic?	YES	NO
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14. Have you ever experienced any complication or illness following dental treatments?	YES	NO
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15. Do you have any diseases or conditions not listed above?	YES	NO
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16. Have you ever been told you were not eligible to be a blood donor?	YES	NO
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17. Do you use Tobacco? Cigarettes _____ Cigars _____ Pipe _____ Chewing Tobacco _____	YES	NO
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18. FOR WOMEN: Are you pregnant? _____ Taking birth control pills? _____	YES	NO
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Signature of Patient/Guardian _____ Date _____

Dentist's Signature _____ Date _____