Name_____ **Date**_____

MEDICAL HISTORY

Please circle yes or no.

Yes No pregnant, what month? _____.
Yes No artificial joint replacement
Yes No heart attack, heart disease
Yes No angina pectoris
Yes No high blood pressure
Yes No heart murmur, mitral valve prolapse, rheumatic or scarlet fever

Yes No congenital heart defects, or artificial valves

Yes No cardiac pacemaker
Yes No heart surgery
Yes No blood thinners, or daily aspirin
Yes No anemia, bleeding disorders, hemophilia, or bruise easily

Yes No blood transfusion
Yes No leukemia or blood diseases
Yes No stroke, CVA
Yes No epilepsy or seizures
Yes No psychological therapy
Yes No kidney problems
Yes No gastric problems, ulcers

Yes No respiratory problems, tuberculosis, emphysema
Yes No sinus trouble, asthma
Yes No smoking/ tobacco (_____.)
Yes No diabetes
Yes No arthritis
Yes No cancer, chemotherapy, radiation therapy, cortisone medication

Yes No liver disease, hepatitis A, B, C
Yes No HIV+ or AIDS
Yes No drug addictions

Please list any disease, condition, or problem not mentioned above.

_____
_____
_____.

- Are you in any pain? YES / NO
- Are you anxious or nervous about dental treatment? YES / NO
- Have you ever had a bad experience at the dental office? YES / NO
- Medical consult required? Yes / No

MEDICATIONS

Are you allergic or have reacted adversely to any medications? (please circle)

(local anesthetic, novocaine, xylocaine, valium, codeine, vicodin, percocet, darvocet, demerol, sleeping pills, nitrous oxide, penicillin, erythromycin, tetracycline, aspirin, tylenol, ibuprofen, LATEX)

If not mentioned, please list.

_____
_____
_____
_____.

Please list the prescription or over the counter medications you are presently taking.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list your Medical Doctor
Name_____
Phone_____
Address_____

Medical Update:
Date_____
_____
_____
_____**Dr**_____**.**

Date_____
_____
_____
_____**Dr**_____**.**