

NAME _____

DATE OF BIRTH _____

Month / Day / Year

MEDICAL: (If you brought a written list of your medications, please give that to the receptionist.)

1. When was your last medical examination? ____/____/____ (Mo./Yr.)
2. Have you been under a physician's care during the past two years? Yes No
 Physician's Name: _____ If necessary, may we contact? Yes No
 Specialist's Name: _____ If necessary, may we contact? Yes No
3. Within the last 3 years, have you been hospitalized or had surgery? Yes No
 If yes, please give reasons and dates: _____
4. Have you ever been instructed to take ANY medications or precautions before dental appointments? Yes No
 If yes, please explain: _____
5. Are you taking ANY drugs, medications, or treatments at this time? Yes No
 Prescribed: _____
 Over the counter: _____
 Vitamins/herbals: _____
6. Are you allergic to (itching, swelling, rash), or have you ever experienced an unusual reaction to:
 ___ Dental anesthesia ___ Latex ___ Penicillin (of related drugs) ___ Tetracycline ___ Clindamycin (Cleocin)
 ___ Keflex (Cephalexin) ___ Iodine ___ Aspirin/Ibuprofen(Advil, Motrin) ___ Sulfa drugs ___ Tranquilizers (Valium)
 ___ Erythromycin ___ Codeine ___ NSAID (Celebrex, Vioxx, Anaprox) ___ Other _____

7. Check any of the following which you have had or have at present:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Congenital heart defects | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Angina pectoris/chest pain | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Bisphosphonates |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Hemophilia/blood disorder | <input type="checkbox"/> Radiation/Cobalt treatment | <input type="checkbox"/> Pain in jaw joints |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Compromised Immunity
(Lupus,HIV,AIDS) |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> STD |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Hay fever/Allergies/Hives | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Heart failure/attack | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Poor wound healing |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Fainting/Dizzy spells |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Artificial joint/joint surgery | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Mental health issues |
| <input type="checkbox"/> Heart valve damage/prolapse | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Liver disease/Jaundice | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Organ transplant | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Drug addiction |
| <input type="checkbox"/> Stroke/CVA | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Glaucoma | |

8. Do you smoke or use chewing tobacco? Yes No
9. When walking/taking stairs, do you ever stop due to chest pain, shortness of breath or tiredness? Yes No
10. Do your ankles swell during the day? Yes No
11. Do you use **more** than two pillows to sleep? Yes No
12. Have you lost or gained more than 10 pounds in the past year? Yes No
13. Do you ever wake up form sleep short of breath? Yes No
14. Are you on a special diet? Yes No
15. Has your medical doctor ever said you have a cancer or tumor? Yes No
16. Do you have any disease, condition, or problem not listed? Yes No
17. Women: Are you pregnant now? Yes No Due date _____ Do you anticipate becoming pregnant? Yes No
 Are you taking birth control pills? Yes No Are you currently nursing? Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Date _____ Signature of Patient, Parent of Guardian _____

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition
_____	_____
_____	_____
_____	_____
_____	_____