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:

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

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

_____ _____
_____ _____
_____ _____
_____ _____

SUBMIT