MEDICAL HISTORY

NAME ______________________ BIRTH DATE ______________ TODAY'S DATE ______________

		YES	NO
1.	Has your health CHANGED in the past year?	☐	☐
2.	Have you ever been HOSPITALIZED for illness or surgery?	☐	☐
3.	Has a doctor treated you for any condition in the last two years?	☐	☐
4.	Are you ALLERGIC to Penicillin, latex, or any other drug or substance? If yes, what? ______________________	☐	☐
5.	Do you have any other allergies? If yes, what? ______________________	☐	☐
6.	Have you ever experienced BLEEDING that was difficult to stop?	☐	☐
7.	Have you ever had Rheumatic Fever or Heart Murmur?	☐	☐
8.	Do you or have you used tobacco products? If yes, packs per day? ________ How many years? __________	☐	☐
9.	Have you or any member of your family had problems with Anesthetics?	☐	☐
10.	Have you ever taken Fosamax, Actonel, Zometa, Aredia, Boniva, Prolia, or Reclast? If so, please indicate how long ______________________	☐	☐
11.	Have you ever been told by your doctor that you are required to take an antibiotic prior to having dental procedures performed?	☐	☐
12.	Are you taking any MEDICATIONS (even aspirin, vitamins, antacids, supplements)? If so, please list them with dosages: ______________________	☐	☐
13.	Do you have heart trouble, a pacemaker, or have you had any form of heart surgery including a heart valve replacement? If yes, please explain ______________________ ______________________	☐	☐

14. How often do you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

PLEASE INDICATE YES OR NO FOR ANY CONDITION EVEN IF YOU NO LONGER HAVE THEM

	YES	NO		YES	NO
Stroke	☐	☐	Anemia	☐	☐
High Blood Pressure	☐	☐	Ulcers	☐	☐
Low Blood Pressure	☐	☐	Fainting	☐	☐
Chest Pain on mild exertion	☐	☐	Thyroid/Parathyroid Disorders	☐	☐
Short of Breath on mild exertion	☐	☐	Sickle Cell Trait/Disease	☐	☐
Sinus Trouble	☐	☐	Tumors/Growths	☐	☐
Asthma/Lung Disease	☐	☐	Ankles Swell	☐	☐
Tuberculosis	☐	☐	Artificial Joints	☐	☐
Epilepsy/Convulsions	☐	☐	Arthritis	☐	☐
Immune System Problems	☐	☐	Have you even taken Cortisone/Steroids?	☐	☐
Diabetes (I or II)	☐	☐	Hives/Rash	☐	☐
Kidney Disease	☐	☐	TMJ Disorders	☐	☐
Have you ever taken Tetracycline?	☐	☐	History of Human Papilloma Virus (HPV)	☐	☐
Cancer Treatment	☐	☐	HIV or AIDS	☐	☐
Hepatitis B or C or Liver Disease	☐	☐	Herpes Simplex I or II (cold sores)	☐	☐

IF FEMALE, ARE YOU: Pregnant YES ( ) NO ( )
IF FEMALE, ARE YOU: Nursing YES ( ) NO ( )
IF FEMALE, ARE YOU: Taking Birth Control Pills YES ( ) NO ( ) **If YES, please initial addendum below.

ADDENDUM TO CONSENT FORM FOR PATIENTS USING ORAL CONTRACEPTIVES

It has been explained to me, and I understand, that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control, for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. (Patient's Initials)__________

Is there any condition or problem that you think we should know about? YES ( ) NO ( )
If yes, please list ______________________
Is there anything you wish to discuss in private? YES ( ) NO ( )

I HAVE GIVEN THE ABOVE INFORMATION TRUTHFULLY AND IT IS, TO THE BEST OF MY KNOWLEDGE, AN ACCURATE REPRESENTATION OF MY HISTORY AND CURRENT MEDICAL STATUS (OR OF MY DEPENDENT, WHERE APPLICABLE).

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Patient's or Guardian's Signature **Date** **Reviewed by**