

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, chest pains
- 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, arrhythmia
- Yes No heart surgery or stents
- 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, depression
- Yes No kidney problems, renal issues
- Yes No gastric problems, ulcers, bowel disorders

- Yes No respiratory problems, tuberculosis, emphysema, COPD
- Yes No sinus trouble, asthma
- Yes No smoking/ tobacco/smokeless tobacco/vape
- Yes No marijuana Medical consult required? Yes / No
- Yes No diabetes, A1C____average sugar level_____
- Yes No arthritis, what type_____
- Yes No cancer, chemotherapy, radiation therapy, cortisone medication
- Yes No liver disease, hepatitis A, B, C
- Yes No HIV+ or AIDS, immune diseases
- Yes No drug addictions, alcoholism
- Yes No do you use marijuana?

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

MEDICATIONS

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

(local anesthetic, novocaine, xylocaine, valium, codeine, vicodin, percocet, 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.

If list is too long, please attach a medications list.

Please list your Medical Doctor

Name _____
Phone _____
Address _____

For the Doctor: Vitals: _____

Date _____

_____ **Dr** _____

Date _____

_____ **Dr** _____

Medical consult required? Yes / No
Antibiotic pre-medication needed? Yes / No
If yes, please list antibiotic: _____