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Medical History

Today's Date: _______________ Patient Name: _____________________________________

Name/Number of Primary Care Physician: ____
Have you been hospitalized in the last 5 years? Yes / No _______________________________
Please list any medications you are currently taking: ___________________________________
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Are you taking any blood thinners? Yes / No ____
Have you ever taken any bone density drugs? Yes / No _________________________________
Have you had any artificial joint replacement? Yes / No Date of Surgery: ________________
Has it ever been recommended to take antibiotics prior to dental treatment? Yes / No
If yes, name / phone number recommending provider: __________________________
Do you use tobacco of any kind? Yes / No Are you interested in quitting? Very / Slightly / No
Women only:
Are you taking birth control pills? Yes / No
Are you pregnant / nursing? Yes / No Estimated Due Date: ________________________

Do you have any of the following conditions:

AIDS/HIV	Yes / No	Heart attack/Surgery (Date:)	Yes / No
Artificial heart valve	Yes / No	Hepatitis A / B / C	Yes / No
Asthma	Yes / No	High blood pressure	Yes / No
Cancer	Yes / No	Low blood pressure	Yes / No
Chemotherapy/Radiation	Yes / No	Previous endocarditis	Yes / No
Congenital heart disease	Yes / No	Severe headaches/migraines	Yes / No
Diabetes (Type I/II)	Yes / No	Stroke (Date:)	Yes / No
GI reflux	Yes / No	Thyroid disease (Hyper/Hypo)	Yes / No

Allergies – are you allergic to, or have you had any reaction to the following:

Aspirin	Yes / No	Local anesthetics	Yes / No
Barbiturates/sedatives/sleeping pills	Yes / No	Metals	Yes / No
Codeine/other narcotics	Yes / No	Penicillin/other antibiotics	Yes / No
Latex	Yes / No	Sulfa drugs	Yes / No