

Patient Name: _____

Patient's Birth Date: _____

Physician's Name: _____

Physician's Phone #: _____

Cardiologist's Name: _____

Cardiologist's Phone #: _____

Other Specialist: _____

Specialist's Phone #: _____

Previous Dentist: _____

Last Dental Visit: _____

Do you take antibiotic pre-medication prior to dental appointments? Yes No Name _____

Allergic Reactions:

Are you presently taking any medications or pills? Yes No

YES NO

- | | | | | |
|--------------------------|--------------------------|-----------------------------|-------------|------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin | List: _____ | For: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sulfa | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetic (Novocain) | _____ | _____ |
| Other | | _____ | _____ | _____ |

Do you have or have you ever been treated for:

YES NO

YES NO

- | | | | | | |
|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Any Heart Problems _____ | <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack _____ | <input type="checkbox"/> | <input type="checkbox"/> | Lung/Breathing Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina _____ | <input type="checkbox"/> | <input type="checkbox"/> | Asthma _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Bypass _____ | <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker _____ | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke _____ | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur _____ | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in Healing _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse _____ | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever _____ | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joint (knee/hip) _____ | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles/Ulcers _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Any Bleeding Disorders _____ | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia _____ | <input type="checkbox"/> | <input type="checkbox"/> | Drug Abuse _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia _____ | <input type="checkbox"/> | <input type="checkbox"/> | Nervous or Mental Disorder _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Traits _____ | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or Seizures _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusions _____ | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | Adrenal/Pituitary Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Infectious Disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor _____ |

Do you get headaches? YES NO If yes, how frequent/severe? _____

Is there any condition or problem related to your medical history that has not been mentioned? If so, please explain:

Are you happy with your smile? YES NO _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature X: _____ Date: _____

Parent, Patient or Guardian

DENTAL MEDICAL HISTORY