**Medical History**

Your current physical health is: Good Fair Poor Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you allergic to any of the following?**

Amoxicillin Erythromycin Penicillin

Aspirin Jewelry Sulfa Drugs

Codeine Latex Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Anesthetics

**Please list all current medications you are taking:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have or have you experienced any of the following?**

Y N Abnormal Bleeding Y N Drug Abuse Y N Memory Loss

Y N Acid Reflux Y N Emphysema Y N Mitral Valve Prolapse

Y N Alcohol Abuse Y N Epilepsy Y N Occlusal Appliance

Y N Arthritis Y N Glaucoma Y N Pacemaker

Y N Artificial Joints Y N Headaches Y N Psychiatric Care

Y N Artificial Valves Y N Heart Murmur Y N Radiation Treatment

Y N Asthma Y N Heart Surgery Y N Rheumatic Fever

Y N Blood Transfusion Y N Hepatitis: Type\_\_\_\_ Y N Sinus Problems

Y N Cancer \_\_\_\_\_\_\_\_\_\_\_\_ Y N HIV+/AIDS Y N Snoring

Y N Chemotherapy Y N High Blood Pressure Y N Stroke

Y N Congenital Heart Defect Y N Hearing Impaired Y N Thyroid Problems

Y N Depression/Anxiety Y N Kidney Problems Y N Tuberculosis (TB)

Y N Diabetes Y N Liver Disease Y N Ulcers

Y N Vertigo

Has any doctor recommended pre-medication with antibiotics before dental appointments for any reason? Explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any serious medical condition(s) you have experienced: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women: Are you pregnant now? \_\_\_\_\_\_\_\_\_\_\_\_\_ How many months? \_\_\_\_\_\_\_\_\_\_\_\_\_

Are you happy with the appearance of your smile? \_\_\_\_\_\_\_\_\_\_Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any complications following dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything else you would like us to know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Patient/Guardian/Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_