MEDICAL HISTORY

Check the following boxes if you have had any of the following:

☐ AIDS/HIV
☐ Hepatitis Type______________
☐ Fainting/Dizziness
☐ Rheumatic Fever
☐ Artificial Joint
☐ Heart Problems
☐ Skin Rash
☐ Bleeding abnormally
☐ Blood Disease
☐ Cancer Type_________________
☐ Chemical Dependency
☐ Chemotherapy
☐ Radiation Treatment
☐ Circulatory Problems

☐ Congenital Heart Lesion
☐ Epilepsy
☐ Stroke
☐ Respiratory Disease
☐ Asthma
☐ Artificial Heart Valve
☐ Heart Murmur
☐ Pacemaker
☐ Cold Sores
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease

☐ Anemia
☐ Glaucoma
☐ Scarlet Fever
☐ Thyroid Problems
☐ Tonsilitis
☐ Tuberculosis
☐ Tumor on Neck/Head
☐ Ulcer
☐ Venereal Disease
☐ Diabetes
☐ Emphysema
☐ Mitral Valve Prolapse
☐ Psychiatric Care
☐ Sleep Apnea
☐ High Cholesterol

☐ Arthritis
☐ Jaw Pain
☐ Headaches
☐ Back Problems
☐ Special Diet
☐ Shortness of Breath
☐ Sinus Trouble
☐ Cough
☐ Nervousness
☐ Swollen Feet/Ankles
☐ Swollen Neck Glands
☐ Weight Loss
☐ Acid Reflux

Have you been told to pre-medicate with antibiotics before any type of dental treatment? Yes: ☐ No: ☐

If yes, please list: ____

Have you ever had a reaction to Novocain? Yes: ☐ No: ☐

Have you ever used a bisphosphonate? Yes: ☐ No: ☐ If so, when? _________________________

Women: Pregnant: Yes: ☐ No: ☐ Due Date: ___/___/___ Nursing: Yes: ☐ No: ☐

Taking oral contraceptives: Yes: ☐ No: ☐

MEDICATIONS

Are you taking any medications? Yes: ☐ No: ☐

If yes, please list all: ____

Preferred Pharmacy and Location: ______________________________________

ALLERGIES

Do you have any known allergies? Yes: ☐ No: ☐

If yes, please check the boxes next to any known allergies:

☐ Latex ☐ Barbiturates ☐ Sulfa ☐ Codeine

☐ Penicillin ☐ Aspirin ☐ Local Anesthetic ☐ Iodine

Other: ____