



Medical History

Patient Name:
Last First MI Preferred Name

Within the past year, have there been any changes in your general health?

Yes No

If yes please explain:

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name

Please list medications,(including over the counter drugs taken):

Do you have any allergies?

WOMEN ONLY: Are you pregnant?

Yes No

Have you ever been told to take an antibiotic before a dental appt?

Yes No

Do you have heart valve or joint replacements: i.e. hip, shoulder, knee?

Yes No



Please check any of the following that pertain to you

- | | |
|---|---|
| <input type="checkbox"/> ALLERGY TO MEDICATIONS | <input type="checkbox"/> Heart (Surgery, Disease, Attack) |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Arrhythmia |
| <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> PREMED | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Artificial Heart Valve/Pacemaker | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Cortisone Medicine |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Special Diet | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Ulcers/Acid Reflux |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Contact Lenses |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hay Fever/ Allergies/ Hives | <input type="checkbox"/> LATEX SENSITIVITY |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Radiation Therapy/Chemotherapy |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Hepatitis A B C |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Fosamax/ Actonel / Boniva | <input type="checkbox"/> Liver Disease/Jaundice |
| <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Nervous/Anxious |

Do you have any other health issues not listed ?