Medical History

NAME_____ **DOB**_____ **AGE**_____

	Yes	No
1. Are you in good health?	☐	☐
2. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated?_____		
Physician name/phone #/address_____		
3. Have you ever had any serious illness or operation?	☐	☐
If so, what illness or operation?_____		
4. Have you ever been hospitalized?	☐	☐
If so, for what?_____		
5. Are you taking any medicine?	☐	☐
Please list _____		
6. Do you take recreational drugs (marijuana, cocaine, etc.)	☐	☐
7. Are you sensitive or allergic to any medications?	☐	☐

☐Penicillin ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐Motrin ☐ Other_____

8. Do you have or have you had any of the following?

Heart Murmur	Yes No	Joint Replacement	Yes No	Epilepsy/Seizures	Yes No	Anemia	Yes No	Liver Disease	Yes No
High Blood Pressure	Yes No	Hives	Yes No	Heart Ailments/ Attack	Yes No	Ulcers	Yes No	Sinus Trouble	Yes No
Radiation Therapy	Yes No	Cortisone Medicine	Yes No	Hepatitis or Jaundice	Yes No	Glaucoma	Yes No	Blood Disease	Yes No
Rheumatic Fever	Yes No	Excessive Bleeding	Yes No	Fainting Spells	Yes No	Arthritis	Yes No	Drug Addiction	Yes No
Tuberculosis	Yes No	Latex Allergy	Yes No	Chemotherapy	Yes No	Emphysema	Yes No	Kidney Disease	Yes No
Pacemaker	Yes No	Pain in Jaw Joints	Yes No	Venereal Disease	Yes No	Cold Sores	Yes No	H.I.V./Aids	Yes No
Nervous Disorder	Yes No	Respiratory Disease	Yes No	Heart Valve Replacement	Yes No	Bruise Easily	Yes No	Asthma	Yes No
Thyroid Disease	Yes No	Mental Disorder	Yes No	Angina/Chest Pain	Yes No	Head Injuries	Yes No	Hemophilia	Yes No
Tumors/Growths	Yes No	Blood Transfusion	Yes No	Congenital Heart Problems	Yes No	Diabetes	Yes No	Stroke	Yes No
Psychiatric Treatment	Yes No	Cerebral Palsy	Yes No	Heart Surgery	Yes No	Artificial or Prosthetic Joints	Yes No	Allergies (Hay Fever)	Yes No
Serious Allergic Reactions	Yes No	Food Allergy	Yes No	Bronchitis	Yes No	Rheumatic heart disease	Yes No	Lung Disease	Yes No
Blood Thinners	Yes No	Taking Aspirin, Motrin, Aleve	Yes No	Heart Palpitations	Yes No	Autoimmune Disease	Yes No	Muscle or Skeletal Disorder	Yes No

	Yes	No
9. Do you have any disease, condition or problem not listed above?	☐	☐
10. Do you smoke? If yes, how much per day? _____	☐	☐
11. Are you taking/have you ever taken bisphosphonate medications? (Fosamax, Actonel, Boniva, Aredia, Zometa, etc.)	☐	☐
12. Does dental treatment make you nervous?	☐	☐
13. Have you ever had local anesthetic (Novocaine, etc?)	☐	☐
14. Have you ever had an unfavorable reaction to local or general anesthetic?	☐	☐
15. (Women) Do you take birth control pills?	☐	☐
16. (Women) Is there any possibility that you might be pregnant? Are you currently nursing?	☐	☐

Patient Signature_____ **Date**_____
(Parent or Guardian if patient is a minor)

Doctor Signature_____ **Date**_____

Patient (Update)_____ **Date**_____
(Parent or Guardian if patient is a minor)

Doctor Signature (Update)_____ **Date**_____

ASA
1
2
3

ASA
1
2
3