Medical History

(please mark yes or no for each question)

Patient Name: _____
First MI Last Nickname

Reason for today's office visit: _____

	Yes	No	Notes
Are you in good health?			
Height _____ Weight _____ Age _____			
Have there been any changes in your general health in the past year?			
Are you under the care of physician? If yes, date of last visit _____ For what are you being treated?			
Have you had any serious illness, operation or been hospitalized? If yes, please explain:			
Are you allergic to anything (such as latex, tape, antiobiotics, pain medications)? If yes - Please list			

Please indicate if you have had any of the following conditions:

	Yes	No	Notes		Yes	No	Notes
Heart disease				Anemia			
Chest pains				Bleeding problems			
Heart murmur				Stomach ulcers			
Mitral valve prolapse				HIV or AIDS			
Rheumatic fever				Cancer or tumors			
High blood pressure				Radiation treatment			
Artificial heart valve				Chemotherapy			
Pacemaker				Hepatitis or jaundice			
Stroke				Diabetes			
Glaucoma				Thyroid disease			
Fainting spells				Kidney disease			
Asthma				Arthritis			
Lung disease				Artificial joints			
Tuberculosis				Seizures (epilepsy)			
Hay fever/sinusitis				Swollen ankles			
Shortness of breath				Liver disease			
Snoring or sleep apnea				Alcohol/drug abuse			
Delayed healing				Psychiatric disorder			

	Yes	No	Notes
Do you need to premedicate with antibiotics prior to any dental work or surgery?			
Are you currently taking any drugs or medications? If yes - Please list			
Have you ever had any adverse reaction to an anesthetic? If yes - Please list			
Have you ever had or been treated for clicking or pain in your jaw joint (TMJ)? If yes - Please list			
Have you had any unusual problems with previous dental work? If yes - Please list			
Have you ever been prescribed any of the following drugs: Fosamax, Aredia or Zometa?			
Have you ever been treated for or are you taking medication for osteoporosis or any other condition resulting in loss of bone density?			
Is this visit a result of an accident? If yes - Please list			
Do you smoke, vape or use tobacco products?			
Have you ever taken diet pills (such as Fen-Phen or Redux)?			
Are you taking any herbal medications (such as St. John's Wort)?			
Women: Are you taking birth control pills?			
Are you pregnant?			
Are you nursing?			
Do you have any other conditions or problems we should know about prior to treatment? If yes - Please list			
Do you have any history of family diseases that we should know about? If yes - Please list			

Have you been out of the country in the last 21 days? Yes No

I hereby certify that the above information is accurate and complete to the best of my knowledge _____ Date: _____
Patient / Parent or Guardian Signature

Dec 20