

MEDICAL HISTORY

NAME: _____ D.O.B. _____ YES NO

1. Has your health CHANGED in the past year? YES NO
2. Have you ever been HOSPITALIZED for illness or surgery? YES NO
3. Has a doctor treated you for any condition in the last two years? YES NO
4. Are you ALLERGIC to Penicillin, latex, or any other drug or substance?
If yes, please list _____ YES NO
5. Do you have any other allergies? If yes, what? _____ YES NO
6. Have you ever experienced BLEEDING that was difficult to stop? YES NO
7. Have you ever had Rheumatic Fever or Heart Murmur? YES NO
8. Do you currently or have you used tobacco products? If yes, packs per day? _____ How many Years? _____ YES NO
9. Do you have a history of substance abuse or addiction? If yes, please explain _____ YES NO
10. Do you currently use e-cigarettes or any vaping products? If yes, how often _____ YES NO
11. Have you or any member of your family had problems with Anesthetics? YES NO
12. Have you ever taken Fosamax, Actonel, Zometa, Aredia, Boniva, Prolia or Reclast?
If so, please indicate how long _____ YES NO
13. Have you ever been told by your doctor that you are required to take an antibiotic prior to having dental procedures performed? YES NO
14. Are you taking any MEDICATIONS (including aspirin, vitamins, antacids, supplements)?
If so, please list them with dosages: _____ YES NO
15. Do you have heart problems, a pacemaker, or have you had any form of heart surgery including a heart valve replacement? If yes, please explain _____ YES NO
16. How often do you have a drink containing alcohol?
 Never Monthly or less 2-4 times a month 2-3 times a week 4+ per week

PLEASE INDICATE YES OR NO FOR ANY CONDITION EVEN IF YOU NO LONGER HAVE THEM

	YES	NO		YES	NO
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain on Mild exertion	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Parathyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Short of Breath on mild exertion	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait/Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Tumors/Growths	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ankles Swell	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Immune System Problems	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken Cortisone/Steroids?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (I or II)	<input type="checkbox"/>	<input type="checkbox"/>	Hives/Rash	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	TMJ Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken Tetracycline?	<input type="checkbox"/>	<input type="checkbox"/>	History of Human Papilloma Virus (HPV)	<input type="checkbox"/>	<input type="checkbox"/>
Cancer Treatment	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B or C or Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Simplex I or II (cold sores)	<input type="checkbox"/>	<input type="checkbox"/>

IF FEMALE, ARE YOU: Pregnant YES () NO () **If yes, are you: Nursing** YES () NO ()

IF FEMALE, ARE YOU: Taking Birth Control Pills YES () NO () *** If YES, please initial addendum below.

ADDENDUM TO CONSENT FORM FOR PATIENTS USING ORAL CONTRACEPTIVES

It has been explained to me, and I understand, that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control, for one complete cycle of birth control pills, after the course of antibiotics or other medication is complete. (Patients Initials) _____

Is there any condition or problem that you think we should know about? YES () NO ()

If yes, please explain _____

Is there anything else you wish to discuss in private? YES () NO ()

I have given the above information truthfully and it is, to the best of my knowledge, an accurate representation of my history and current medical status (or of my dependent, where applicable).

Patient's or Guardian's Signature _____

Date _____

Reviewed by _____