

Medical History

Your name: _____ Today's Date: _____

Are you currently under the care of a physician? (Describe) _____

Do you have a history of heart disease/surgery/attack? (Describe) _____

Have you been hospitalized in the last 5 years? (Describe) _____

Below, please mark any conditions you currently have, or have ever had:

- | | |
|--|---|
| <input type="checkbox"/> High blood pressure (hypertension) | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> High blood pressure controlled by medications | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Chemotherapy/radiation treatment |
| <input type="checkbox"/> Bacterial endocarditis | <input type="checkbox"/> Hay fever/sinus trouble |
| <input type="checkbox"/> Abnormal heart condition | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Shunt | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Artificial joints (hip, knee, ect) | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Chronic respiratory illness |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Diabetes (circle: type 1 or type 2) | <input type="checkbox"/> Acid reflux |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Chemical dependency |
| <input type="checkbox"/> Hepatitis, any form | <input type="checkbox"/> Abnormal bleeding from a cut |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Ever taken Phen-Phen (diet drug) | <input type="checkbox"/> Serious accident/head or facial trauma |
| <input type="checkbox"/> Ever taken Fosamax/Boniva/Actonel | |

Have you ever been told that you need antibiotics prior to dental treatment? _____

Are you allergic to (check all that apply): Penicillin other antibiotics

Local anesthetics Sulfa drugs Latex Other (Describe): _____

Do you take or use any of the following: Tagamet (Cimetidine) Antacids

Grapefruit juice or extract (regularly) Tobacco (circle: cigarettes, cigar, chew)

List any medications you are currently taking and reason for taking. Please include any herbal remedies or supplements (if more space is needed, please use the back of this form)

1. _____ 2. _____
3. _____ 4. _____

Woman only: Check the boxes below if you are:

pregnant planning a pregnancy nursing taking birth control pills

Patient Signature: _____ Date: _____

Office Use Only: BP: _____ Pulse: _____ taken with: pulse-ox digital manual

Provider Signature: _____ Date: _____

More information on reverse side

Alerts entered in Dentrax