

The following confidential information is important for the dentist to know in planning your dental care. Please answer each question as completely as you can. Thank you.

Patient Name _____ Date of Birth _____

Health Information - Medical

Physician (name and location) _____

Are you presently under a physician's care? If yes, please explain. _____

Have you ever had a serious illness or accident? If yes, please explain. _____

List all medications or drugs (and dosages) that you are taking. _____

Are you allergic to: Penicillin Codeine Latex Other

- Heart disease Yes No
- Circulatory problems Yes No
- Heart murmur Yes No
- Rheumatic fever Yes No
- Congenital heart defect Yes No
- Abnormal blood pressure Yes No
- Diabetes Yes No
- Epilepsy/seizures Yes No
- AIDS/HIV positive Yes No
- Abnormal bleeding Yes No
- Blood transfusion Yes No
- Prosthetic implant Yes No
- Hepatitis Yes No
- Strep throat Yes No
- Herpes simplex (cold sores) Yes No
- Asthma Yes No
- Back problems Yes No

- Arthritis Yes No
- Fainting spells Yes No
- Eating disorders Yes No
- Headaches Yes No
- Weekly
- Monthly
- Nervousness Yes No
- Mental health care Yes No
- Radiation therapy Yes No
- Sinus trouble Yes No
- Thyroid problem Yes No
- Tonsilitis Yes No
- Tumors Yes No
- Ulcers Yes No
- Seasonal Allergies (Hayfever) Yes No
- Other Yes No

Have you ever been advised to be premedicated prior to dental treatment for any of the above conditions? Yes No

If yes, reason: _____

The above information is correct to the best of my knowledge.

Patient/Parent Signature _____ Date _____

D.D.S. Signature _____ Date _____

Updates (Staff use)
Note changes in medical history or address and phone number.

No change Refer Progress Notes
Signed: _____ Date: _____

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