PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Birth date_____

If minor, parent's names _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ **Are you required to Pre-Medicate before any dental treatment**
- ❑ Abnormal bleeding after any surgery (heavy bleeder)
- ❑ AIDS or HIV positive
- ❑ Allergies
- ❑ Arthritis
- ❑ Artificial joint or valves
- ❑ Asthma
- ❑ Blood Problems (Anemia)
- ❑ Blood transfusion
- ❑ Bone or joint problems
- ❑ Cancer/Tumor
- ❑ Diabetes TYPE 1 or TYPE 2
- ❑ Epilepsy or Neurological disorders
- ❑ Hayfever or sinus trouble
- ❑ Heart defect
- ❑ Heart murmur
- ❑ Heart Pacemaker
- ❑ Heart problems
- ❑ Herpes or cold sores
- ❑ High or low blood pressure (circle one)
- ❑ Kidney disease q Hepatitis, jaundice or other liver disease
- ❑ Mitral valve prolapse
- ❑ Stroke
- ❑ Thyroid problems
- ❑ Tuberculosis or other lung problems

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Aspirin
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Codeine or other narcotics
- ❑ Latex materials
- ❑ Local anesthetics ("Novocain")
- ❑ Other:_____
- ❑ Penicillin or other antibiotics
- ❑ Sulfa drugs

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

❑ Do you smoke or use chewing tobacco? ❑ yes ❑ no

Women:

- ❑ Check if you are pregnant or could be pregnant
  Expected delivery date:_____
- ❑ Check if taking hormones or contraceptives

Why are you seeking dental treatment? _____

Name of your physician and phone number :_____

Do you have any disease, condition, or problem not listed above?_____

Please list all medications you are taking:_____

Signature of patient (or parent) _____ Date _____