Medical Information

Rate your general health (please circle):
Excellent Good Fair Poor

Name and phone number of your physician:

____

____

Reason for exam: ______________________________

Are you presently taking any medication or drugs?
Yes No

Prescriptions: ______________________________

Over-the-counter: ______________________________

Herbal Supplements: ______________________________

Do you have any allergies, or have you had any adverse reactions to medications, etc. Yes No

Penicillin Dental anesthetics Latex Iodine

Others: ______________________________

Do you have a history of tobacco use? Yes No

Past Present

Type: Cigarettes Pipe Chew Cigars

How much: ______________________________

For how long? ______________________________

Have you ever taken Phen-fen or other prescription diet medications? Yes No

List of others ______________________________

Have you ever had a serious illness that required hospitalization? Yes No

If yes, then for what and when? ______________________________

____

Have you ever had abdominal bleeding after a surgical procedure? Yes No

If yes, explain ______________________________

____

Please check any of the following that you have had or been treated for:

- ☐ Heart murmur
- ☐ Rheumatic fever / rheumatic heart disease
- ☐ Chest Pain
- ☐ Angina
- ☐ Heart attack; When? ______________________________
- ☐ Prosthetic heart valve
- ☐ Pacemaker
- ☐ Mitral valve prolapse
- ☐ Heart Disorder: ______________________________
- ☐ Stroke: When? ______________________________
- ☐ High Blood Pressure
- ☐ Swollen ankles
- ☐ Difficulty in breathing
- ☐ Asthma
- ☐ Tuberculosis; When? ______________________________
- ☐ Emphysema
- ☐ Sinus Problems
- ☐ Chronic Cough
- ☐ Respiratory illness: ______________________________
- ☐ Rapid weight gain or loss
- ☐ Thyroid disease or malfunction
- ☐ Kidney disease or malfunction
- ☐ Epilepsy / Seizures; Explain ______________________________
- ☐ Frequent headaches
- ☐ Earaches
- ☐ Glaucoma
- ☐ Chemotherapy: When? ______________________________
- ☐ Radiation therapy; When? ______________________________
- ☐ Hepatitis; Type: ☐A ☐B ☐C ☐D ☐E
- ☐ Liver Disease
- ☐ Alcohol or drug addiction
- ☐ Anemia
- ☐ Hemophilia
- ☐ Other blood disorders
- ☐ Back problems
- ☐ Cancer; Type: ______________________________
- ☐ Diabetes
- ☐ Artificial joints (knee, hip, shoulder, etc.)
  When placed? ______________________________
- ☐ AIDS / ARC / HIV+
- ☐ Shingles
- ☐ Herpes
- ☐ Cold sores / Fever Blisters
- ☐ Women: Are you pregnant? Yes No
  Due date: ______________________________
- ☐ Transplant; Type: ______________________________
- ☐ Other: ______________________________
- ☐ None of the above

I have reviewed the information indicated on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist and his staff to determine appropriate and healthful dental treatment. If there is a change in my medical status, I will inform the dentist and his staff. I request and fully consent to the performance of any additional tests or procedures which are deemed necessary after a complete clinical examination. I have been informed that these procedures will be discussed with me prior to them taking place.

Signature ______________________________ Date ______________________________