AD DENTISTRY

Medical History – Patient's Name: ____Date: ___________________

Information that you think is insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you have or have you ever been treated for:						Allergic Reaction (hives/swelling) to:		
Heart Murmur	Yes	No	Do you smoke	Yes	No	Penicillin	Yes	No
Mitral valve prolapse	Yes	No	Drug Abuse	Yes	No	Erythromycin	Yes	No
Heart valve defect	Yes	No	Asthma	Yes	No	Sulfa	Yes	No
Heart valve replacement	Yes	No	Bronchitis	Yes	No	Codeine	Yes	No
Angina	Yes	No	Emphysema	Yes	No	Aspirin	Yes	No
Heart attack	Yes	No	Tuberculosis	Yes	No	Latex	Yes	No
Bypass	Yes	No	Sinus Trouble	Yes	No	Local Anesthetic (Novocain)	Yes	No
Pacemaker	Yes	No	Other lung/breathing problems	Yes	No	Allergies to other	Yes	No
Other heart problems	Yes	No	Difficulty healing	Yes	No	medications or substances?		
Pregnancy	Yes	No	Diabetes	Yes	No	Please list: ___________________		
Artificial joint (hip/knee)	Yes	No	Thyroid problems	Yes	No	______________________________		
High blood pressure	Yes	No	Adrenal/Pituitary Problems	Yes	No	Cancer/tumor	Yes	No
Low blood pressure	Yes	No	Liver problems/dysfunction	Yes	No	Other growths	Yes	No
Anemia	Yes	No	Stomach trouble/ulcers	Yes	No	Chemotherapy/Radiation therapy	Yes	No
Hemophilia	Yes	No	Nervous or mental disorder	Yes	No	Sexually Transmitted Diseases	Yes	No
Sickle cell trait	Yes	No	Epilepsy or Seizures	Yes	No	Other Infectious Diseases	Yes	No
Blood transfusions	Yes	No	Alcoholism	Yes	No	HIV/AIDS	Yes	No
High Cholesterol	Yes	No	Current Pregnant	Yes	No			

Do you need to take antibiotic premedication prior to dental appointments? □ Yes □ No □ Don't know

Are you presently taking any medications, pills, or supplements?

Name: ____ For: _________________________________

Name: ____ For: _________________________________

Name: ____ For: _________________________________

Are you currently being treated by a physician? Yes No Other: ________________________________

By signing below, I certify that the above information is complete and accurate to the best of my knowledge. I will inform the dentist of any changes in my health status or my medications.

____ ____

Patient/Guardian Signature Date Doctor Signature Date