MEDICAL HISTORY FORM

Please take sufficient time to **CAREFULLY** and **COMPLETELY** fill out this form. It is very important and can directly affect the treatment that you receive in this office.

		Yes	No
1.	Are you now, or have you been, under a physician's care during the past 3 years?	☐	☐
2.	Have you been in the hospital at any time during the past 3 years?	☐	☐
3.	Do you have allergies or sensitivities to drugs SUCH AS, BUT NOT LIMITED TO penicillin, novocaine, codeine, aspirin, etc? Latex?	☐	☐

4. **Please list ALL drugs or products to which you are ALLERGIC on the line below.**

_____

5. **Please list the names of ALL medications that you are currently taking.** Include birth control pills, any "natural herbal medicines," and other "over the counter" drugs. IF YOU ARE NOT TAKING ANY MEDICATION AT THIS TIME, PLEASE WRITE THE WORD '**NONE**' ON THE LINES BELOW.

_____

_____

		Yes	No
6.	Have you ever taken steroid medication in the past?	☐	☐
7.	Are you currently dieting or HAVE YOU EVER taken diet pills?	☐	☐
8.	Have you recently been taking "blood thinners" or aspirin?	☐	☐
9.	Have you ever had any excessive bleeding requiring special treatment?	☐	☐
10.	Are you subject to fainting, dizziness, nervous disorders, convulsions or epilepsy?	☐	☐
11.	Have you ever had breathing difficulties, such as asthma, bronchitis, emphysema or tuberculosis?	☐	☐
12.	Have you, or any immediate family members, ever had a problem with general anesthesia?	☐	☐
13.	Are you, or could you be pregnant? Nursing?	☐	☐
14.	Do you smoke cigarettes?	☐	☐
15.	Has any **physician - M.D. (not dentist)** ever told you to take antibiotics **prior** to dental work?	☐	☐
16.	Do you have problems with your jaw joint (TMJ)? Clicking, popping, pain, limitation of opening?	☐	☐

Please check yes or no to any of the following problems that you have had in the past:

	Yes	No		Yes	No		Yes	No
Angina (chest pain)	☐	☐	Diabetes	☐	☐	Hepatitis/Liver Disease	☐	☐
Rheumatic Fever	☐	☐	High Blood Pressure	☐	☐	Anemia	☐	☐
Mitral Valve Prolapse	☐	☐	Any Form of Cancer	☐	☐	Thyroid Disease	☐	☐
Heart Murmur	☐	☐	Kidney Problem	☐	☐	AIDS/HIV	☐	☐
Artificial Heart Valve	☐	☐	Glaucoma	☐	☐	Immune System Problems	☐	☐
Heart Attack/Disease	☐	☐	Ulcers	☐	☐	Any Medical Condition	☐	☐
Irregular Heartbeat	☐	☐	Shortness of Breath	☐	☐	Not Listed Above		
Pacemaker	☐	☐	Artificial Joint	☐	☐			
Angioplasty/Bypass	☐	☐	Stroke/TIA	☐	☐			
Surgery	☐	☐	Psychiatric Care	☐	☐			
Heart Surgery	☐	☐						

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon or any member of his staff legally responsible for any errors or omissions that I may have made in the completion of this medical history form.

Signature of Patient/Guardian _____ Date _____

Reviewed By _____ Date _____