PATIENT MEDICAL HEALTH HISTORY

Patient Name: ____________________________

Physician's Name: __________________________
City, State, Zip ___________________________

Are you currently under the care of a Physician? N ☐ Y ☐
If yes, for what? ___________________________

Have you ever been hospitalized? N ☐ Y ☐
If yes, for what? ___________________________

Are you taking any medications?
(prescriptions or over-the-counter) N ☐ Y ☐
If so, please list the names and dosages of each:
____
____
____

Are you required to take antibiotic premedication before dental treatment? N ☐ Y ☐

Abnormal Blood Pressure? N ☐ Y ☐
If yes, what is it usually? ______/______

Are you allergic to or have you had a reaction to:

- Latex or Rubber N ☐ Y ☐
- Local Anethetics N ☐ Y ☐
- Penicillin or Amoxicillin N ☐ Y ☐
- Clindamycin N ☐ Y ☐
- Aspirin or Ibuprofen N ☐ Y ☐
- Codeine or Hydrocodone N ☐ Y ☐
- Sedatives N ☐ Y ☐
- Other: ___________________________

Do you use tobacco? N ☐ Y ☐
If so, how much do you smoke/chew per day? __________
For how long? ________________________________

Height: __________ Weight: __________

Are you taking Tagament (Cimetidine) N ☐ Y ☐
Do you take Antacids? N ☐ Y ☐

Do you regularly take dietary supplements or herbal medicines? N ☐ Y ☐

If so, do you regularly take any of the following?

- Diet or Energy Supplements N ☐ Y ☐
- Echinacea N ☐ Y ☐
- Garlic, Ginger, Ginko, or Ginseng N ☐ Y ☐
- Kava N ☐ Y ☐
- St. John's Wort N ☐ Y ☐
- Valerian N ☐ Y ☐
- Vitamin E >400 I.U. N ☐ Y ☐
- Fish Oil > 3grams/day N ☐ Y ☐

Do you regularly use natural or herbal oral health products? N ☐ Y ☐

Have you recently substituted herbs for over the counter or prescription drugs? N ☐ Y ☐

Do you drink Soda Pop regularly? N ☐ Y ☐
If yes, how much and how often? ________________

Women Only:

- Are you pregnant? N ☐ Y ☐
- Are you nursing a baby? N ☐ Y ☐
- Are you taking birth control pills? N ☐ Y ☐
- Are you on Hormone Therapy? N ☐ Y ☐
- Do you have Osteoporosis? N ☐ Y ☐
- If yes, have you had any treatment(s) for Osteoporosis? N ☐ Y ☐
- If yes, what treatment(s)? ________________
____

For the following questions circle yes or no if you have or have had in the past any of the conditions. Your answers are for our records only and will be confidential.

	No	Yes		No	Yes
Heart Murmur (mitral valve prolapse)	☐	☐	Psychiatric Care	☐	☐
Anemia or Blood Disease	☐	☐	Sore/Enlarged Lymph Nodes	☐	☐
Diabetes	☐	☐	Tumor, Cancer, Chemotherapy	☐	☐
Epilepsy or Seizures	☐	☐	Cold Sores or Canker Sores	☐	☐
Hepatitis A, B or C	☐	☐	Stomach or Intestinal Problems	☐	☐
Rheumatic Fever or Scarlet Fever	☐	☐	Swelling of the Feet /Ankles	☐	☐
High Blood Pressure	☐	☐	Stroke or Heart Attack	☐	☐
Asthma	☐	☐	Artificial Joint Replacement	☐	☐
Angina or Chest Pain	☐	☐	Glaucoma	☐	☐
Emphysema or Respiratory Illness	☐	☐	Excessive Bleeding from a cut	☐	☐
Abnormal Heart Condition or Congenital Heart Problem	☐	☐	Liver Disease (including Jaundice)	☐	☐
Fainting or Dizzy Spells	☐	☐	Drug or Alcohol Use	☐	☐
Kidney Disease	☐	☐	Unintentional Weight Loss/Gain	☐	☐
Heart Disease, Surgery, Pacemaker	☐	☐	Excessive Thirst	☐	☐
Venereal Disease	☐	☐	H.I.V. Infection/AIDS	☐	☐
Shortness of Breath	☐	☐	Thyroid or Parathyroid Disease	☐	☐
Artificial Heart Valve	☐	☐	Cortisone Treatment	☐	☐