**Medical History Form**

*-We understand that health history forms can be time consuming, but what goes on in your body can effect your mouth and vice versa. Please answer to the best of your ability so that we are better equipped to serve you and your needs. Thank you. -*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes | No |  | Yes | No |
| **Heart Problems** |  |  | **Endocrine Issues** |  |  |
| Chest Pain |  |  | Diabetes |  |  |
| Blood pressure problems |  |  | **Intestinal Problems** |  |  |
| Heart murmur |  |  | Ulcers |  |  |
| Heart valve problem |  |  | Special Diet |  |  |
| Artificial heart valve |  |  | **Allergy** **Problems** |  |  |
| Rheumatic Fever |  |  | Hay fever |  |  |
| Pace Maker |  |  | Asthma |  |  |
| Taking Heart Medication (if yes, please note in Medication List) |  |  | If yes to asthma, do you require and inhaler/have it with you? |  |  |
| **Bone or Joint Problems** |  |  | Skin conditions/rash |  |  |
| Arthritis |  |  | **Blood Problems** |  |  |
| Back or Neck pain |  |  | Easy bruising |  |  |
| If yes, can you lay back? |  |  | Blood disease (anemia) |  |  |
| If yes, do you require a pillow? |  |  | Ever require a transfusion? |  |  |
| Joint Replacement |  |  | HIV/AIDS/Hepatitis   |  |  |  | | --- | --- | --- | | **Women** | Yes | No | | Are you taking contraceptives or other hormones? |  |  | | Are you pregnant? |  |  | | If yes, what trimester? |  | | | Expected delivery date? |  | | |  |  |
| If yes, within the past 2 years? |  |  |
| If yes, do you require pre-medication before all dental treatments? |  |  |

**Have you reacted adversely to any of the following?**

Office Use Only

BP: \_\_\_\_\_/ \_\_\_\_\_\_\_\_\_ P: \_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No |  |
| Local anesthetics (“Novocain”) |  |  |  |
| Penicillin or other antibiotics |  |  |  |
| Sulfa drugs |  |  |  |
| Barbiturates, sedatives, or sleeping pills |  |  |  |
| Aspirin, Acetaminophen, or Ibuprofen |  |  |  |
| Codeine, Demerol, or other narcotics |  |  |  |
| Latex or rubber dam |  |  |  |
| Allergy not listed above: |  |  |  |
|  |  |  |  |

Office Use Only

Last Cleaning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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