# MEDICAL HISTORY

**Your Name: ________________________________________ Date of Birth: ____________________**

How would you describe your present health: *(circle one)* Excellent Good Fair Poor

Have you been a patient in a hospital during the past two years? [ ] YES [ ] NO

Have you been under a doctor's care during the past two years? [ ] YES [ ] NO

Do you take medicines or drugs-i.e. aspirin, vitamins, hormones, antacids? [ ] YES [ ] NO

If so, list current medications: ________________________________________________

Are you allergic to penicillin or any other medicines or drugs?

If so, list here: ____________________________________________________________

Have you ever had any adverse reactions to any drugs, anesthetics, sedatives, or narcotics?

If so, list here: ____________________________________________________________

Are you a diabetic or borderline diabetic?

If so, what is your current A1C and date taken: ____________________________________

Any immunodeficiency, AIDS or HIV infection diagnosis? [ ] YES [ ] NO

Are you required to restrict your work or activity in any way? [ ] YES [ ] NO

Are you taking any blood thinners-i.e. Plavix, Warfarin, Aspirin, Eliquis? [ ] YES [ ] NO

Do you use tobacco? If so, how much __________ per day

Do you drink alcohol? If so, how much __________ per day

Do you have any substance abuse? [ ] YES [ ] NO

## Check any of the following which you may have had:

| | | |
|---|---|---|
| **[ ] Heart Trouble** | **[ ] High Blood Pressure** | **[ ] Persistent Cough** |
| **[ ] Congenital Heart Lesions** | **[ ] Low Blood Pressure** | **[ ] Sinus Troubles** |
| **[ ] Heart Murmur** | **[ ] Glaucoma** | **[ ] Tuberculosis** |
| **[ ] Prolapsed Mitral Valve** | **[ ] Diabetes** | **[ ] Asthma** |
| **[ ] Heart Surgery** | **[ ] Hepatitis or Jaundice** | **[ ] Epilepsy** |
| **[ ] Rheumatic Fever** | **[ ] Ulcers** | **[ ] Arthritis** |
| **[ ] Cardiac Pacemaker** | **[ ] Kidney Disease** | **[ ] Stroke** |
| **[ ] Latex Allergy** | **[ ] Psychiatric Care** | **[ ] History of oral or other cancer** |
| **[ ] Heart Valve Prosthesis** | **[ ] Osteoporosis** | **[ ] Joint Replacement Prosthesis** |

**Has a physician directed you to take antibiotics prior to having dental treatment?** [ ] YES [ ] NO

***If yes, please take your pre-med antibiotic as prescribed by your physician prior to your appointment.***

Physician Name: ______________________________________________________________

Do you have any disease, condition or problems not listed above that you feel we should know about?
If so, please explain: _________________________________________________________

**Signature of Patient or Legal Guardian** **Date**