

\_\_\_\_\_  
Patient Name

General Health:

Excellent  Good  Fair  Poor

Are you under the care of a physician?

Yes  No

If yes, please explain

\_\_\_\_\_

\_\_\_\_\_

Name and address of family physician:

\_\_\_\_\_

Are you wearing a pacemaker or heart valve prosthesis?  Yes  No

Have you been hospitalized or had a serious illness in the past 5 years?

Yes  No

If yes, please explain:

\_\_\_\_\_

Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?

Yes  No

Are you taking any kind of medication (prescribed or non-prescribed) or drug at this time?  Yes  No

If yes, please explain:

\_\_\_\_\_

Are you currently taking or have you taken in the past 5 years any of the following medications?

Fosamax  Boniva  
 Actonel  Didronel  
 Skelid  Aredia  
 Zometa

Do you need to premedicate for dental treatment?  Yes  No

Are you pregnant?  Yes  No  
How many months? \_\_\_\_\_

Have you ever undergone Root Canal Treatment?  Yes  No

Circle any of the following to which you're allergic or have had an unusual reaction to:

Penicillin	Aspirin	Demerol
Sulfa Drugs	Darvon	Nitrous Oxide
Erythromycin	Codeine	Steroids
Novocaine (Xylocaine)	Valium (tranquilizers)	Motrin
Sedatives & Barbiturates		

Other

Circle any of the following which you have had:

Heart Trouble	Asthma	AIDS or HIV
Heart Murmur	Cough	Venereal Disease
Rheumatic Fever	Hay Fever	Herpes
High Blood Pressure	Hives or Skin Rash	Arthritis
Angina	Diabetes	Kidney Trouble
Stroke	Tuberculosis	Radiation Therapy
Congenital Heart Disease	Psychiatric Treatment	Epilepsy
Hepatitis	Glaucoma	Ulcers
Lung Disease	Convulsions	Blood Disorders
Anemia	Sinus Trouble	Thyroid Trouble
Migraine	Fainting Spells	

Is there anything else about your health we should know?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any special needs?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your chief dental complaint?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature

Date

## Medical History