Medical Health History Form

Name_______________________________________ Name of Spouse______________________________

If patient is under 18 name of parents_____________________ In case of emergency, notify: ________________

Address_____________________________________ City_______________ State_____ Zip__________

Social Security #___________________________ Birth Date________________ Sex__________________

Home Phone______________________________ Work Phone_____________________________________

E-Mail Address____

Who is your medical doctor?___________________________ Phone_________________________________

Please answer yes or no to the following:

Do you have or have you ever had any of these heart conditions?

Artificial or replacement valve Yes No Heart murmur Yes No Rheumatic Fever Yes No
Pacemaker Yes No Mitral valve prolapse Yes No Other: _______________
Stent or Shunt Yes No High blood pressure Yes No _______________

Do you have or have you ever had:

Jaundice Yes No Liver disease Yes No Hepatitis Yes No If yes, Type___________

Are you allergic to any of the following medications:

Penicillin Yes No Sulfa Yes No Codeine Yes No
Amoxicillin Yes No Aspirin Yes No Other _______________
Tetracycline Yes No Iodine Yes No _______________

Yes No Are you allergic to latex?
Yes No Are you currently taking any blood thinners (such as coumadin)?
Yes No Have you ever had major surgery (organ transplant, open heart surgery, etc.)?
Yes No Have you had any surgeries which involved placement of an artificial joint replacement or pins?
Yes No Do you routinely take antibiotic pre-medication for dental visits?
Yes No Have you ever or are you currently undergoing chemotherapy or radiation treatments?
Yes No Do you have a bone supported dental implant?
Yes No Are you a diabetic? If yes Type I or Type II
Yes No Have you had tuberculosis?
Yes No Do you have any breathing problems, respiratory problems or lung conditions?
Yes No Do you have or have you had a venereal disease such as Papilloma Virus, Herpes, Syphilis, or Gonorrhea?
Yes No Have you ever tested positive for HIV (the AIDS virus)?
Yes No Do you have any food allergies?
Yes No Are you anemic?
Yes No Are you pregnant?
Yes No Do you use tobacco? What form and how much? ______________________________________

Do you have any other condition of which our office should be aware? If yes please explain
____

Are you currently taking medications? Please list: ____
____

In case of emergency who should we contact? ____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature____ Date__________________

Dentist's Signature______________________________________ Date__________________