MEDICAL HISTORY - ADULT

The following information is necessary to achieve optimal safety in providing your dental care. All information is strictly confidential, for use in this office only.

NAME_____ **DATE OF BIRTH**_____

Physician's Name_____ **List Current Medications:**_____

Physician's Address_____ _____

Physician's Phone_____ _____

Has a physician ever told you that you require antibiotics prior to dental treatment?_____

Circle any of the following which you have at present or have had:

Heart Failure
Heart Disease
Heart Attack
Angina Pectoris
Heart Murmur
Valve Prolapse
Congenital Heart Lesions
Artificial Heart Valve
Pacemaker
Heart Surgery
Rheumatic Fever
Scarlet Fever
High Blood Pressure
Low Blood Pressure
Stroke

Anemia
Excessive Bleeding
Ulcers
Kidney Disease
Epilepsy or Seizures
Narcolepsy
Fainting/Dizzy Spells
Nervousness
Eating Disorder
Psychiatric Treatment
Sickle Cell Disease
Bruise Easily
Strept Throat
Drug Addiction
Alcoholism
Headaches
Emphysema

Cough
Tuberculosis
Asthma
Hay Fever
Sinus Trouble
Allergies
Allergy to Latex
Hives
Diabetes
Thyroid Disease
Radiation Treatment
Chemotherapy
Arthritis
Rheumatism
Auto Immune
Artificial Joint
Joint Replacement

Cortisone Medication
Pain in Jaw Joint
Liver Disease
Hepatitis A (infectious)
Hepatitis B (serum)
Jaundice
Hemophilia
Oral Herpes
Genital Herpes
Canker Sores
Venereal Disease
AIDS

YES NO

___ ___ Have you been patient in the hospital during the past 5 years?
___ ___ Have you been under the care of a physician during the last 5 years?
___ ___ Have you taken any prescription drugs during the last 5 years?
___ ___ Are you allergic to (i.e. itching, rash, swelling)or made sick by medications?
If yes explain:_____
___ ___ Have you ever had any excessive bleeding requiring special treatment?
___ ___ Do you tire or become short of breath easily?
___ ___ Do your ankles swell during the day?
___ ___ Do you use more than 2 pillows to sleep?
___ ___ Have you unintentionally lost weight in the past year?
___ ___ Has your physician ever said you have cancer or a tumor?
___ ___ Do you have any disease, condition or problem not listed here?
___ ___ Is there anything else I should know about your medical history?_____

_____

PLEASE CONTINUE REVERSE SIDE

Have you ever been tested for AIDS? If yes when?_____
Are you HIV positive (infected with the AIDS virus) ?_____

The Center for Disease Control (CDC) feels that the following put you at risk for infection by the AIDS virus and Hepatitis C. Have you been in one of the following groups since 1977?

YES NO

1. Had a blood transfusion.
2. Received a clotting factor.
3. Engaged in male-to-male sexual contact.
4. Used drugs intravenously.
5. Had sexual contact with someone in one of the above groups
6. Were you or a sexual partner born in Haiti, Cental or East Africa?

Women:

_____ Are you currently practicing birth control?
_____ Is there any possibility you are pregnant?

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 if medications change, I will inform the doctor at the next appointment without fail.

DATE_____SIGNATURE_____

TO BE SIGNED AT SUBSEQUENT APPOINTMENTS:

There has been no change in the status of my health from that stated above.

DATE_____INITIALS_____Rx Meds_____

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