Medical Information

Physician's Name:_____ Phone_____

Date Of Last Visit:_____ Have you had any serious illnesses or operations Yes ❑ No ❑

If yes, describe: _____

Are you ill or currently under the care of a physician? Yes ❑ No ❑

If yes, describe: _____

Allergies (including medication, Latex, jewelry, metal, etc.): _____

Current Medications: (including aspirin, over-the-counter medications, etc.)_____

_____

Any Family History of : Heart Disease ❑ Cancer ❑ Diabetes ❑ Seizures ❑

Do any of the below conditions apply to you? Please check Yes or No.

	Yes	No		Yes	No
High Blood Pressure / Hypertension			Anemia		
Low Blood Pressure			Jaundice / Liver Disease		
Heart Murmur			Bleeding Disorder / Hemophilia		
Rheumatic Fever			Kidney Disease		
Mitral Valve Prolapse (MVP)			Organ Transplant		
Angina Pectoris / Chest Pain			Cancer (Type_____)		
Heart Attack			Chemotherapy		
Prosthetic (artificial) Heart Valve			Radiation Therapy		
Irregular rapid heart beat			Epilepsy / Seizure		
Pacemaker / Implanted defibrillator			Stomach Ulcer		
Heart Disease			Colitis Intestinal Problem		
Heart or Bypass Surgery			Osteoarthritis		
Malnourishment			Rheumatoid Arthritis / Lupus		
Stroke			Artificial Joints / Screws		
Emphysema			Sexually Transmitted Disease (STD)		
Asthma			AIDS / HIV		
Diabetes (Type_____)			Tuberculosis (TB)		
Thyroid Disease / Goiter			Psychiatric Treatment		
Liver Disease			Alcohol / Substance Abuse		
Hepatitis (Type_____)			Blood Transfusion		
Renal Dialysis			Drug Addiction		
Unexplained Weight Change			Cancer / Radiation Therapy		
Alcoholism			Tobacco Habit		
Steroid Medication			Bisphosphonates		

FEMALES: Are you taking birth control pills? Yes ❑ No ❑

Are you or might you be pregnant? Yes ❑ No ❑ Estimated Delivery:_____

Do you have any disease, condition, or problem not listed above? Yes ❑ No ❑

If Yes, Please describe:_____

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

Patient / Guardian:_____ Date: _____

Doctor:_____ Date: _____