Name_____ Date_____

MEDICAL HISTORY

Please circle yes or no.

Yes No pregnant, what month? _____.
Yes No artificial joint replacement
Yes No heart attack, heart disease
Yes No angina pectoris, chest pains
Yes No high blood pressure
Yes No heart murmur, mitral valve prolapse, rheumatic or scarlet fever

Yes No congenital heart defects, or artificial valves

Yes No cardiac pacemaker, arrhythmia
Yes No heart surgery or stents
Yes No blood thinners, or daily aspirin
Yes No anemia, bleeding disorders, hemophilia, or bruise easily

Yes No blood transfusion
Yes No leukemia or blood diseases
Yes No stroke, CVA
Yes No epilepsy or seizures
Yes No psycholoical therapy, depression
Yes No kidney problems, renal issues
Yes No gastric problems, ulcers, bowel disorders

Yes No respiratory problems, tuberculosis, emphysema, COPD
Yes No sinus trouble, asthma
Yes No smoking/ tobacco/smokeless tobacco/vape
Yes No marijuana Medical consult required? Yes / No
Yes No diabetes, A1C____average sugar level_____
Yes No arthritis, what type_____
Yes No cancer, chemotherapy, radiation therapy, cortisone medication
Yes No liver disease, hepatitis A, B, C
Yes No HIV+ or AIDS, immune diseases
Yes No drug addictions, alcoholism
Yes No do you use marijuana?

Please list any disease, condition, or problem not mentioned above.

_____
_____
_____.

- Are you in any pain? YES / NO
- Are you anxious or nervous about dental treatment? YES / NO
- Have you ever had a bad experience at the dental office? YES / NO

MEDICATIONS

Are you allergic or have reacted adversely to any medications? (please circle)

(local anesthetic, novocaine, xylocaine, valium, codeine, vicodin, percocet, demerol, sleeping pills, nitrous oxide, penicillin, erythromycin, tetracycline, aspirin, tylenol, ibuprofen, LATEX)

If not mentioned, please list.

_____
_____
_____.

Please list the prescription or over the counter medications you are presently taking.

_____
_____
_____
_____
_____
_____
_____
_____
_____

If list is too long, please attach a medications list.

Please list your Medical Doctor
Name_____
Phone_____
Address_____

For the Doctor: Vitals:_____

Date_____
_____
_____**Dr** _____

Date_____
_____
_____**Dr** _____

Medical consult required? Yes / No
Antibiotic pre-medication needed? Yes / No
If yes, please list antibiotic:_____