MEDICAL HISTORY

Name_____Date_____

Are you allergic or had a reaction to any of the following? Please check those that apply.

___ Aspirin
___Barbiturates
___Codeine
___Penicillin
___Erythromycin
___Jewelry or any metals
___Latex
___Sedatives
___Tetracycline
___Dental Anesthetics
___Other_____
___No known drug allergies

Are you taking any of the following? Please check those that apply.

___Acetaminophen
___Antibiotics
___Antihistamines
___Aspirin
___Blood Thinners
___Blood Pressure Medication
___Cold Remedies
___Digitalis / Heart Medication
___Insulin / Diabetes Drugs
___Nitroglycerine
___Prescription Diet Medication
___Recreational Drugs
___Steroids / Cortisone
___Thyroid Medication
___Tranquilizers
___Other:_____
___I am not taking any meds

Have you had, or do you have, any of the following? Please check those that apply.

___Abnormal Bleeding
___Anemia
___Arthritis
___Artificial Bones / Joints
___Artificial Valves
___Asthma
___Blood Transfusion
___Cancer
___Chemotherapy
___Chicken Pox
___Colitis
___Congenital Heart Defect
___Diabetes
___Difficulty Breathing
___Emphysema
___Epilepsy
___Fainting Spells
___Fever Blisters
___Glaucoma
___Hay Fever
___Headaches
___Heart Attack
___Heart Murmur
___Heart Surgery
___Hemophilia
___Hepatitis
___Herpes
___High Blood Pressure
___HIV or AIDS
___Hospitalization Recently
___Kidney Problems
___Liver Disease
___Low Blood Pressure
___Lupus
___Mitral Valve Prolapse
___Pacemaker
___Persistent Cough
___Psychiatric Problems
___Radiation Treatments
___Rheumatic Fever
___Scarlet Fever
___Seizures
___Shingles
___Substance Abuse
___Sickle Cell Disease
___Sinus Problems
___Stroke
___Thyroid Problems
___Tonsillitis
___Tuberculosis (TB)
___Ulcers
___Venereal Disease
___Other_____

For women only: Please check those that apply.

___I am pregnant. Month____
___I am nursing.
___I might be pregnant
___I am taking birth control pills.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. This information will be held in the strictest confidence and understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental service I may need.

Signature_____Date_____