MEDICAL HISTORY

Name of Primary Care Physician_______________________________Phone#___________________________

Are you currently under the care of a Physician? Yes No

If yes, for what reason?____

Date of last visit to your Primary Care Physician?____

Are you taking any medications , prescription or herbal? Yes No
If yes, please list all medications: ____

____

Do you need to be premedicated with an anitbiotic before dental treatment? Yes No
If yes, please explain____

*Are you allergic to any medications? Yes No
If yes , please list____

Have you ever had any of the following diseases or medical problems:

Yes	No	Heart Attack/Stroke	Yes	No	Cancer/Chemotherapy
Yes	No	Heart Murmur	Yes	No	Rheumatic Fever
Yes	No	Heart Surgery/Pacemaker	Yes	No	HIV + / Aids
Yes	No	Hepatitis	Yes	No	Shingles
Yes	No	Anemia	Yes	No	Kidney Problems
Yes	No	High / Low Blood Pressure	Yes	No	Fever Blisters
Yes	No	Sinus Problems	Yes	No	Severe Headaches
Yes	No	Diabetes	Yes	No	Epilepsy/Seizures/Fainting
Yes	No	Drug/Alcohol Abuse	Yes	No	Tuberculosis (TB)
Yes	No	Hemophilia/Abnormal Bleeding	Yes	No	Sickle Cell Disease
Yes	No	Venereal Disease	Yes	No	Ulcers/Digestive Problems
Yes	No	Asthma/Emphysema	Yes	No	Arthritis
Yes	No	Snoring	Yes	No	Breathing Problems
Yes	No	Grinding / Clinching teeth	Yes	No	TMJ

Have you had, or do you have any other medical condition of which we should know?

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Do you experience stress or anxiety when you visit a dental office? Yes No
Date of your last dental visit_________________________
Name of previous dentist___________________________phone#_____________________________