

MEDICAL HISTORY

Please check any of the following which you have had or have at the present

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Venereal Disease
(Syphilis, Gonorrhea) | <input type="checkbox"/> Any Form of Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Blood in your stool | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Food Allergies |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Unexplained Gain or Loss of
Weight | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Drug or Alcohol Abuse |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Increase in Thirst | <input type="checkbox"/> Chronic Diarrhea or
Constipation |
| <input type="checkbox"/> X-ray or Cobalt Treatment | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Constant or re-occurring
Fever |
| <input type="checkbox"/> Cortisone or Steroid | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Medicine | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Frequent Vomiting |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Difficulty Urinating |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Chronic Bronchitis | |
| <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Hepatitis | | |
| <input type="checkbox"/> Easy or Chronic Fatigue | <input type="checkbox"/> Blood Transfusion | | |

Do You Have Any of the Following Drug Allergies?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Codeine |
| <input type="checkbox"/> Y <input type="checkbox"/> N Darvon | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nitrous Oxide | <input type="checkbox"/> Y <input type="checkbox"/> N Valium |
| <input type="checkbox"/> Y <input type="checkbox"/> N Percodan | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Local Anesthetic | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ | |

Are you under a physicians' care? What for? _____

Have you ever been admitted to a hospital? _____

Are you taking any medications? What? _____

Family Physician _____ Phone (____) ____ - _____

Y N Have you ever had a general anesthetic?

Y N Have you ever had a bleeding problem following any type of surgery or tooth extractions?

If Yes, please explain: _____

Y N Do you smoke? If Yes, How much? _____

Y N Do you drink alcoholic beverages?

Y N Are you Pregnant? Obstetrician _____

Y N Have you u ever had a drug dependency problem?

If Yes, please explain: _____

Y N Do you use recreational drugs?

Y N Do you have difficulty opening your mouth?

Y N Do you have pain or noise in your jaw joints?

Y N Do you have pain in your temples or cheeks?

Y N Do you have pain chewing or yawning?

Y N Do you clinch or grind your teeth?

Y N Have you ever been treated for TMJ problems?

Approximate date of last medical exam? ____/____/____

Is there any other medical or dental information we should know about? _____

Notice to Patients Taking Oral Contraceptives (Birth Control Pills)

The effectiveness of birth control pills can be reduced by taking or using some drugs used in dental surgery. These drugs include pain medication, antibiotics and drugs used in sedation and anesthesia.

This is to inform you of this possibility and when indicated, other forms of birth control should be used during the month that oral surgery is performed. _____ (please initial)

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 my medicines change, I will inform the doctor at the next appointment without fail.

Date ____/____/____ Signature of Patient, Parent or Guardian _____