Personal Medical History

Name of your physician: _____ Telephone number_____

Please answer these important questions.

Please check any of the following which you have had.

____ Diabetes
____ Heart trouble
----- Congenital heart lesions
----- Heart murmur
____ Mitral valve prolapse
____ Stroke
____ Pacemaker
____ High blood pressure
____ Alcoholisim
____ Anemia
____ Hepatitis
____ Mononucleosis
____ Sinus trouble
____ Cancer
____ Radiation treatment
____ Psychiatric trmt.
____ Cough
____ Asthma
____ Arthritis
____ Rheumatic fever
____ Epilepsy
____ Tuberculosis
____ Thyroid disease
____ Ulcer
____ Persistent sores
____ Jaundice
____ Glaucoma
____ Liver disease
____ Aids
____ HIV positive
____ Venereal disease
____ Snoring

1) Are there any medical Problems we should be aware of? If yes, please explain. Yes___No___
_____

2) Have you been under the care of a physician in the past two years? If yes, for what? Yes___No___
_____

3) Have you taken any drugs or medications during the past year? If yes, please list. Yes___No___
_____
_____
_____
_____

4) Have you been a patient in the hospital in the past two years? If yes, please explain. Yes____No___
_____

5) Have you ever had any excessive bleeding requiring special treatment? If yes, explain. Yes___No___
_____

6) (Women) Are you pregnant? Yes___No___

7) Do you ever have any pain or clicking on opening or closing your mouth? Yes___No___
_____

8) Do you have frequent headaches? If yes explain. Yes___No___
_____

9) Are you self-conscious about your breath? Yes___No___

10) Are you a smoker? _____ Yes___No___

11) I am allergic to: _____
_____

12) Have you been asked to pre-medicate with antibiotics prior to having dental treatment? _____

Thank you for your assistance. This information is very valuable when it comes to your dental health.

Dr. Notes:
_____
_____
_____

Patient signature: _____ Date _____