



<b>PATIENT NAME:</b>		<b>DATE:</b>

**MEDICAL HISTORY**

GENERAL HEALTH:  EXCELLENT  GOOD  FAIR  POOR

- Y  N Under a physician's care now?
- Y  N Any hospitalization in the past 5 years? \_\_\_\_\_
- Y  N Any serious illnesses/surgeries? \_\_\_\_\_
- Y  N Use tobacco in any form? If Yes, Type: \_\_\_\_\_
- Y  N Is pre-medication required before dental visits due to heart condition or artificial joint?
- Y  N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*
- Y  N Do you snore?
- Y  N Have you ever been told you snore?
- Y  N Have you ever been diagnosed with Sleep Apnea?
- Y  N Do you ever wear a c-pap or any other device?
- Y  N Has anyone told you that you hold your breath while sleeping?

FEMALE PATIENTS:  Y  N Currently nursing?  Y  N Currently pregnant? Due Date: \_\_\_\_\_

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients?  Y  N  
If yes, please describe: \_\_\_\_\_

Is there anything important about your medical condition we have not asked?  Y  N If yes, please describe: \_\_\_\_\_

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):  NONE

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> ACID REFLUX            | <input type="checkbox"/> BULIMIA                 | <input type="checkbox"/> HEARING PROBLEMS           | <input type="checkbox"/> PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> ADHD                   | <input type="checkbox"/> CANCER/MALIGNANCY       | <input type="checkbox"/> HEART ATTACK               | <input type="checkbox"/> RADIATION/CHEMO       |
| <input type="checkbox"/> AIDS/HIV               | <input type="checkbox"/> CEREBRAL PALSY          | <input type="checkbox"/> HEART DISEASE              | <input type="checkbox"/> RESPIRATORY DISEASE   |
| <input type="checkbox"/> ANEMIA                 | <input type="checkbox"/> CHEMICAL DEPENDENCY     | <input type="checkbox"/> HEART MURMUR               | <input type="checkbox"/> RHEUMATIC FEVER       |
| <input type="checkbox"/> ANOREXIA               | <input type="checkbox"/> CHICKEN POX             | <input type="checkbox"/> HEPATITIS                  | <input type="checkbox"/> SINUS PROBLEMS        |
| <input type="checkbox"/> ANXIETY                | <input type="checkbox"/> CONVULSIONS             | <input type="checkbox"/> HIGH BLOOD PRESSURE        | <input type="checkbox"/> STROKE                |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DEPRESSION              | <input type="checkbox"/> KIDNEY DISEASE             | <input type="checkbox"/> THYROID CONDITION     |
| <input type="checkbox"/> ARTIFICIAL JOINTS      | <input type="checkbox"/> DIABETES                | <input type="checkbox"/> LIVER PROBLEMS             | <input type="checkbox"/> TUBERCULOSIS          |
| <input type="checkbox"/> ARTHRITIS              | <input type="checkbox"/> DIZZINESS/FAINTING      | <input type="checkbox"/> MITRAL VALVE PROLAPSE      | <input type="checkbox"/> ULCERS                |
| <input type="checkbox"/> ASTHMA                 | <input type="checkbox"/> EPILEPSY/SEIZURES       | <input type="checkbox"/> MONONUCLEOSIS              | <input type="checkbox"/> VENEREAL DISEASE      |
| <input type="checkbox"/> AUTISM/ASPERGER'S      | <input type="checkbox"/> FREQUENT EAR INFECTIONS | <input type="checkbox"/> PACEMAKER                  |  |
| <input type="checkbox"/> BLEEDING DISORDER      | <input type="checkbox"/> FREQUENT HEADACHES      | <input type="checkbox"/> OTHER – PLEASE LIST: _____ |  |

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

- |   |                                  |   |   |                               |
|---|----------------------------------|---|---|-------------------------------|
| <input type="checkbox"/> ASPIRIN                    | <input type="checkbox"/> CODEINE | <input type="checkbox"/> LACTOSE INTOLERANCE    | <input type="checkbox"/> SLEEPING PILLS               | <input type="checkbox"/> NONE |
| <input type="checkbox"/> ANESTHETIC – LOCAL         | <input type="checkbox"/> DAIRY   | <input type="checkbox"/> METAL SENSITIVITY      | <input type="checkbox"/> SULFA DRUGS                  |                               |
| <input type="checkbox"/> BARBITURATES               | <input type="checkbox"/> LATEX   | <input type="checkbox"/> NITROUS OXIDE SEDATION | <input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS |                               |
| <input type="checkbox"/> OTHER – PLEASE LIST: _____ |                                  |   |   |                               |

