Medical History Form

Name For your health's sake, you must be accurate. Date For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during you initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. 1. Have you had any serious illnesses? No 2. Have you lost time from work at any time because of serious illness? Yes No 3. Are you under the care of a physician at present?______Yes No 4. Are you taking any medicines now or in the past year?______Yes No If so, please list medication and reason for taking it: 5. Are you allergic or have you had a reaction to: No No c. Sulfa drugs_____ No d. Barbiturates, sedatives, or sleeping pills_______Yes No e. Codeine or other narcotics_______Yes No f. Aspirin______Yes No g. Iodine______Yes No h. Latex___ ____Yes No i. Tetracycline______Yes No j. Other___ No 6. Are you taking any blood thinner medications (aspirin, Plavix, Coumadin, Warfarin) ______Yes No 7. Are you taking any bone sparing medications (Boniva, Fosamax) ______Yes No 8. Have you ever had complications from taking local anesthesia? _______Yes No 9. Have you ever had any operations? If so, please list_______Yes No 10. Have you ever had a blood transfusion? Yes No 11. Do you presently wear contact lenses?______Yes No 12. Do you have or have you had any of the following: ☐ Heart Failure ☐ Emphysema ☐ AIDS/HIV ☐ Heart Disease or Attack ☐ Chronic Bronchitis ☐ Hepatitis A (infectious) ☐ Angina Pectoris ☐ Cough ☐ Hepatitis B (serum) ☐ High Blood Pressure ☐ Tuberculosis (TB) ☐ Liver Disease ☐ Heart Murmur ☐ Asthma ☐ Yellow Jaundice ☐ Rheumatic Fever ☐ Hay Fever ☐ Blood Transfusion ☐ Conginital Heart Lesions ☐ Sinus Trouble ☐ Drug or Alcohol Abuse ☐ Hempophilia ☐ Scarlet Fever ☐ Allergies or Hives ☐ Artificial Heart Valve \Box Diabetes (type 1 or 2) ☐ Venereal Disease (Syphilis,Gonorrhea) ☐ Mitral Valve Prolapse ☐ Thyroid Disease ☐ Genital Herpes ☐ Heart Pacemaker ☐ X-ray or Cobalt Treatment ☐ Cold Sores ☐ Heart Surgery ☐ Chemotherapy (Cancer, Leukemia) ☐ Epilepsy or Seizures ☐ Artificial Joint ☐ Arthritis ☐ Fainting or Dizzy Spells □ Nervousness □ Anemia ☐ Osteoporosis ☐ Psychiatric Treatment ☐ Stroke ☐ Rheumatism ☐ Kidney Trouble ☐ Cortisone Medicine ☐ Sickle Cell Disease ☐ Ulcers ☐ Glaucoma ☐ Bruise Easily 13. Do you have any disease, condition or problem not listed? Yes No Are you pregnant now?______Are you practicing birth control?_____ 14. WOMEN: Yes No Yes No Do you anticipate becoming pregnant?_____ No To the best of m 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 of dentistry at the next appointment without fail. Signature PARENT OR GUARDIAN, IF PATIENT IS A MINOR) ВP Pulse History Reviewed____