OBEIDDENTAL

Patient Medical History

Name (Last, First Middle): _____

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you have or have you ever been treated for:

	YES	NO
Heart Murmur*	❑	❑
Mitral Valve Prolapse*	❑	❑
Heart Valve Defect*	❑	❑
Angina	❑	❑
Stroke	❑	❑
Heart Attack	❑	❑
Bypass	❑	❑
Pacemaker	❑	❑
Other Heart Problems	❑	❑
Rheumatic Fever	❑	❑
Artificial Joint	❑	❑
High Blood Pressure	❑	❑
Low Blood Pressure	❑	❑
Anemia	❑	❑
Hemophilia	❑	❑
Sickle Cell Trait	❑	❑
Blood Transfusions	❑	❑
Other Blood Disorders	❑	❑
Do You Smoke	❑	❑
Asthma	❑	❑

	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Tuberculosis	❑	❑
Sinus Trouble	❑	❑
Breathing Problems	❑	❑
Difficulty Healing	❑	❑
Diabetes	❑	❑
Thyroid Problems	❑	❑
Adrenal/Pituitary Problems	❑	❑
Liver Problems	❑	❑
Hepatitis/Jaundice	❑	❑
Kidney Problems	❑	❑
Stomach Ulcers	❑	❑
Mental Illness	❑	❑
Epilepsy or Seizures	❑	❑
Alcoholism	❑	❑
Drug Abuse	❑	❑
Cancer/Tumor	❑	❑
Other Growths	❑	❑
Chemotherapy	❑	❑

	YES	NO
STD	❑	❑
HIV/AIDS	❑	❑
Other Infectious Disease	❑	❑
Are your pregnant?	❑	❑
Allergic Reaction:		
Penicillin	❑	❑
Erythromycin	❑	❑
Sulfa	❑	❑
Codeine	❑	❑
Aspirin	❑	❑
Latex	❑	❑
Local Anesthetic	❑	❑

Allergies to other medications or substances? Please list:

_____

*Do you need to take antibiotic premedication prior to dental appointments? ❑ YES ❑ NO Type: _____

Are you presently taking any prescription or over-the-counter medications? ❑ YES ❑ NO

If so, what medications:

Name: _____ For: _____

Name: _____ For: _____

Name: _____ For: _____

Are you presently being treated by a physician? ❑ YES ❑ NO

If so, physician's name and phone number: _____

I certify that the above information is complete and accurate to the best of my knowledge. I will inform the dentist of any changes in my health status or my medications.

Patient/Guardian Signature: _____ Date: _____