# MEDICAL HEALTH HISTORY

PATIENT NAME: _____

**Do you have a joint replacement or heart condition which requires antibiotic pre-medication 1 hour prior to EVERY dental appointment? YES ☐ NO ☐**

PRIMARY CARE PHYSICIAN: _____ PHONE(S): _____

Are you allergic to or have you ever had any reactions to the following?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| **PENICILLIN** | ☐ | ☐ | **LATEX** | ☐ | ☐ |
| Local Anesthetics | ☐ | ☐ | Sedatives | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ | Iodine | ☐ | ☐ |
| Barbiturates | ☐ | ☐ | Aspirin | ☐ | ☐ |

**Other Allergies** _____

Are you taking any medication(s) including non-prescription medicine? YES ☐ NO ☐

If yes, what medication(s) are you taking? _____

Do you use alcohol, tobacco, or other drugs? YES ☐ NO ☐

Are you on any blood thinners? (eg:) ☐ ☐

Plavix Warfarin Coumadin Aspirin
Xarelto Pradaxa Eliquis
***(circle one)***

Physician who prescribes: _____

Phone # _____

WOMEN ONLY:

| | YES | NO |
|---|---|---|
| a) Are you pregnant or think you might be pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking birth control pills? | ☐ | ☐ |
| d) Are you taking Bisphosphonates? (eg: Fosamax) | ☐ | ☐ |

Do you have or have you ever had the following?

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Heart Attack | ☐ | ☐ | Asthma | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | Emphysema | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ | Respiratory Problems | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Cardiac Pacemaker | ☐ | ☐ | Cancer | ☐ | ☐ | High Blood Pressure | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | Leukemia | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ |
| Joint Replacement or Implant | ☐ | ☐ | Radiation Treatment | ☐ | ☐ | Anemia | ☐ | ☐ |
| IBS | ☐ | ☐ | Stroke | ☐ | ☐ | Diabetes | ☐ | ☐ |
| Stomach Troubles/Ulcers | ☐ | ☐ | Fainting/Seizures | ☐ | ☐ | Thyroid Problem | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Epilepsy/Convulsions | ☐ | ☐ | Kidney Disease | ☐ | ☐ |
| Angina | ☐ | ☐ | Hepatitis | ☐ | ☐ | Arthritis | ☐ | ☐ |
| Chest Pains | ☐ | ☐ | Jaundice | ☐ | ☐ | Hay Fever/Allergies | ☐ | ☐ |
| Arrhythmia | ☐ | ☐ | AIDS/HIV Infections | ☐ | ☐ | Frequently Tired | ☐ | ☐ |

COMMENTS _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____

PATIENT, PARENT, OR GUARDIAN DATE