PATIENT DENTAL & MEDICAL HISTORY

How would you describe your health? **(Please circle one)** **Excellent** **Good** **Fair** **Poor**

Are you currently being treated for any illness or medical condition?…………………………Yes _____No_____

If yes, please describe____

Who is treating you for this condition? **NAME**____________________________ **PHONE**________________________

Have you ever had any kind of surgery?………………………………………………….…...Yes_____No_____

If yes, Please list ____

Have you ever required a blood transfusion or blood thinner?…………………………………. Yes_____No_____

Do you require antibiotics (premed) before dental appointments?………………………………Yes_____No_____

Please list any medications you are currently taking: (If you carry a medication list, we will be happy to make a copy) ____

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Please specify any allergic or adverse reactions you have ever had to LATEX, anesthetics, antibiotics or any other medications. ____

PLEASE CIRCLE ANY PRESENT OR PAST ILLNESSES YOU NOW HAVE OR HAVE HAD IN THE PAST:

Heart murmur or prolapsed valve (MVP)	Thyroid problems	Hepatitis **A, B, or C**
Prosthetic heart valve	Joint prosthesis (hip, knee, etc.)	HIV / AIDS
Rheumatic fever or rheumatic heart disease	Diabetes	Cancer ___________________
Congenital heart disease	Stomach ulcers or Colitis	Radiation or Chemotherapy
Cardiovascular disease	Jaundice or Liver disease	Oral Herpes
Heart attack or Chest pain	Dialysis or Kidney problems	Depression or psychiatric disorder
Stroke or TIA	High Blood Pressure	(TMJ) joint problems
Bleeding disorder (e.g. Anemia)	Epilepsy, fainting spells or seizures	Asthma or sinus trouble

If female, are you pregnant? Yes____ No _____ what month? ________ are you nursing? Yes _____ No ______

Do you take birth control pills? Yes__ No __ **If yes, be advised that if you take antibiotics, an alternate method of birth control must be used.**

Is there any information we should know about your health? ____

Whom may we thank for referring you? ____

I HAVE REVIEWED THE INFORMATION, AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION WILL BE USED BY THE DENTIST TO HELP DETERMINE APPROPRIATE AND HEALTHFUL DENTAL TREATMENT. IF THERE IS ANY CHANGE IN MY MEDICAL STATUS, I WILL INFORM THE DENTIST.

Signature ____Date ___________________________________

All signatures must be by parent or guardian if patient is under the age of 18

Reviewed by Dr. Michael Schwarze __________ on ___/___/___
Reviewed by Dr. Suman Bathina __________ on ___/___/___
Reviewed by Dr. Cory Malagise __________ on ___/___/___