

Note: Pursuant to the Health Care Portability & Accountability Act of 1996 this is a proprietary document that contains protected health information (phi). This document may not be viewed by persons for which the information appearing herein is not legitimate job related information associated with rendering health treatment or appropriate administrative support to the patient.

Medical History: Certain illnesses and medications may make it necessary for us to alter your dental treatment. In our endeavor to provide you with the most appropriate health care, it is necessary to collect the following information about your health. Please indicate by checking yes or no for all descriptions that are part of your medical profile. Please be assured that this document will be treated with the utmost confidentiality.

Patients Name:

Conditions

- Abnormal Bleeding Yes No
- Allergy Problems Yes No
- Anemia Yes No
- Arthritis Yes No
- Artificial Heart Valve Yes No
- Asthma Yes No
- Back or Neck Pain Yes No
- Blood Pressure Problem Yes No
- Blood Disorders Yes No
- Blood Transfusion Yes No
- Bone or Joint Problems Yes No
- Bruise Easily Yes No
- Cancer / Tumor Yes No
- Chest Pain Yes No
- Cosmetic Surgery Yes No
- Diabetes Yes No
- Emphysema Yes No
- Epilepsy or Seizures Yes No
- Fainting Spells Yes No
- Fever Blisters Yes No
- Frequent Nosebleeds Yes No
- Frequent of Severe Headaches Yes No
- Glaucoma Yes No
- HIV-Positive / AIDS Yes No
- Hay Fever Yes No
- Heart Murmur Yes No
- Heart Problems Yes No
- Heart Valve Problem Yes No
- Hemophilia Yes No
- Hepatitis, Jaundice, Liver Problems Yes No
- Herpes or Other STD Yes No
- Joint Replacement Yes No
- Kidney or Bladder Problem Yes No
- Pacemaker Yes No
- Premedication Required by MD Yes No
- Radiation Therapy Yes No
- Respiratory Problems Yes No
- Rheumatic Fever Yes No
- Shortness of Breath Yes No
- Sinus Problems Yes No
- Skin Rashes Yes No
- Special Diet Yes No
- Stroke Yes No
- Taken Fen-Phen Yes No
- Thyroid Problems Yes No
- Tuberculosis Yes No
- Ulcers Yes No

For Women

- Are you using Birth Control Yes No
- Are you pregnant Yes No
- Are you nursing Yes No

Medication Allergies

- Aspirin Yes No
- Codeine Yes No
- Dental Anesthetics Yes No
- Erythromycin Yes No
- Penicillin Yes No
- Sulfa Yes No
- Tetracycline Yes No

Other Allergies

- Jewelry Yes No
- Metals Yes No
- Latex Yes No

Other Information

- Do you use tobacco products? Yes No
- Do you drink alcohol? Yes No
- History of alcohol abuse? Yes No
- Are you on a special diet? Yes No
- If so, which one?
- Primary Care Physician
- Physician's Phone Number
- Have you ever been hospitalized? Yes No
- If so, when & purpose

Please list all medications that you are taking

Dental History / Information

- Are you apprehensive? Yes No
- Satisfied with color of teeth? Yes No
- Any broken or chipped teeth? Yes No
- Do you have dental pain? Yes No
- Are your teeth crowded? Yes No
- How often do you brush?
- How often do you floss?

Additional Information you would like us to know

Signatures

- Patient
- Date
- Doctor