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MEDICAL HISTORY

Please answer the following questions to the best of your knowledge. Although prosthodontists primarily treat the mouth area, medical problems or medications could have a significant impact on your dental treatment. Your answers are confidential.

Y N Are you in good health?
Y N Are you under the care of physician? Date of last physical examination: _____
Y N Have you had any illness, operation, or been hospitalized in the past 5 years? _____
Y N Are you taking any medications?
If yes, please list ALL medications you are taking:

Are you allergic to any of the following?
Y N Aspirin
Y N Codeine
Y N Latex
Y N Local Anesthetic
Y N Penicillin
Y N Sulfa drugs
Y N Other Allergies
If yes, please list allergy/allergies:

Please indicate if presence of any of following medical conditions:
Y N Abnormal (High/low) Blood pressure
Y N AIDS / HIV
Y N Anemia / Bleeding Problems
Y N Artificial Heart Valves
Y N Blood Disease
Y N Congenital Heart Lesions
Y N Heart Problems
Y N Pacemaker
Y N Arthritis/Rheumatism / Gout
Y N Artificial Joints / Bones
Y N Asthma
Y N Cancer
Y N Diabetes
Y N Emphysema
Y N Glaucoma
Y N Radiation Treatment (Xray/Cobalt)

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Y N Shortness of breath (Breathing problems)
Y N Sinus Trouble
Y N Stoke/History of stroke.
If yes, when was the last incident? _____ Are you on blood thinner? Y / N
Y N Thyroid Problems
Y N Tuberculosis
Y N Ulcer
Y N Epilepsy
Y N Fainting / Dizziness
Y N Headaches
Y N Hepatitis
Y N Herpes
Y N Kidney/ Liver Disease
Y N Psychiatric Care
Y N Operations? If Y, Describe:
Y N Hospitalized? If Y, Describe:

Do you have any other medical conditions that we should know about?

Y N Do you smoke or chew tobacco product(s)?
Y N Do you drink alcohol? If yes, how frequent do you drink _____
Y N Do you currently have or ever had a substance abuse problem?
Y N Pregnant?
Y N Nursing?

Do you normally take antibiotics prior to dental appointments?
Y N
Are you currently on any blood thinner medication?
Y N

I have read and understand the above questions. I will not hold my prosthodontist/endodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Patient Signature: _____Date: _____
Signature of Guardian/Authorized Representative: _____