MEDICAL INFORMATION

Allergies: Are you allergic to or have you had a
Reaction to: Local anesthetics..... Y N DK
Aspirin..... Y N DK
Penicillin or other antibiotics..... Y N DK
Barbiturates, sedatives, or sleeping pills..... Y N DK
Sulfa drugs..... Y N DK
Codeine or other narcotics..... Y N DK

Metals..... Y N DK
Latex (rubber)..... Y N DK
Iodine..... Y N DK
Hay fever/seasonal..... Y N DK
Animals..... Y N DK
Food..... Y N DK
Other.....

Artificial (prosthetic) heart valve..... Y N DK
Damaged valves in transplanted heart..... Y N DK
Unrepaired, cyanotic CHD..... Y N DK
Repaired CHD with residual defects..... Y N DK

Previous infective endocarditis..... Y N DK
Congenital heart disease..... Y N DK
Repaired (completely) in the last 6 months..... Y N DK

Cardiovascular disease..... Y N DK
Heart attack..... Y N DK
Low blood pressure..... Y N DK
Other heart defects..... Y N DK
Rheumatic fever..... Y N DK
Anemia..... Y N DK
AIDS or HIV infection..... Y N DK
Rheumatoid arthritis..... Y N DK
Bronchitis..... Y N DK
Tuberculosis..... Y N DK
Chronic pain..... Y N DK
Malnutrition..... Y N DK
Ulcers..... Y N DK
Glaucoma..... Y N DK
Epilepsy..... Y N DK
Sleep disorder..... Y N DK
Kidney problems..... Y N DK
Persistent swollen glands..... Y N DK
Sexually transmitted disease Y N DK

Angina..... Y N DK
Congestive heart failure..... Y N DK
Damaged heart valves..... Y N DK
Mitral valve prolapsed..... Y N DK
Rheumatic heart disease..... Y N DK
Blood transfusion..... Y N DK
Arthritis..... Y N DK
Systemic lupus..... Y N DK
Emphysema..... Y N DK
Cancer/Chemo/radiation tx... Y N DK
Diabetes Type I Type II..... Y N DK
Gastrointestinal disease..... Y N DK
Thyroid problems..... Y N DK
Hepatitis, jaundice..... Y N DK
Fainting spells, seizures..... Y N DK
Mental health disorders..... Y N DK
Night sweats..... Y N DK
Severe headaches/migraines Y N DK
Excessive urination..... Y N DK

Arteriosclerosis..... Y N DK
Heart murmur..... Y N DK
High blood pressure..... Y N DK
Pacemaker..... Y N DK
Abnormal bleeding..... Y N DK
Hemophilia..... Y N DK
Autoimmune disease..... Y N DK
Asthma..... Y N DK
Sinus trouble..... Y N DK
Chest pain upon exertion.... Y N DK
Eating disorder..... Y N DK
G.E. Reflux/heartburn..... Y N DK
Stroke..... Y N DK
Liver disease..... Y N DK
Neurological disorders..... Y N DK
Recurrent infections..... Y N DK
Osteoporosis..... Y N DK
Rapid weight loss..... Y N DK

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No
Name of physician or dentist making recommendation:_____ Phone:_____
Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:_____ Date_____