MEDICAL HISTORY

ARTIN
DENTAL OFFICE

Patient Name _____ Nickname_____ Birthdate_____

Name of Physician, Address, phone #_____

Date of last physical exam _____Purpose_____

What is your estimate of your general health? (circle the one applies) Poor Fair Good

HAVE YOU EVER HAD THE FOLLOWING:

1. hospitalization for illness or injury	Y	N	20. thyroid or parathyroid disease	Y	N
2. allergic reaction to ■ aspirin, ibuprofen, acetominophen ■ penicillin ■ erythromycin ■ tetracycline ■ codeine ■ local anaesthetic ■ fluoride ■ metals (gold, stainless steel) ■ latex ■ any other			21. hormone deficiency	Y	N
			22. high cholesterol	Y	N
			23. diabetes	Y	N
			24. stomach or duodenal ulcer	Y	N
			25. digestive disorders	Y	N
			26. arthritis	Y	N
			27. glaucoma	Y	N
			28. contact lenses	Y	N
			29. head or neck injuries	Y	N
			30. epilepsy, convulsions, seizures	Y	N
			31. viral infections and cold sores	Y	N
			32. any lumps or swellings in the mouth	Y	N
			33. hives, skin, rash, hay fever	Y	N
			34. venereal disease	Y	N
			35. hepatitis (type)	Y	N
3. heart problems	Y	N	36. HIV / AIDS	Y	N
4. heart murmur	Y	N	37. tumor, abnormal growth, cancer	Y	N
5. rheumatic fever	Y	N	38. radiation therapy	Y	N
6. scarlet fever	Y	N			
7. high blood pressure	Y	N	39. chemotherapy	Y	N
8. low blood pressure	Y	N	40. emotional problems	Y	N
9. stroke	Y	N	41. psychiatric treatment	Y	N
			42. antidepressant medication	Y	N
			43. alcohol / drug dependency	Y	N
10. artificial prosthesis (heart valve or joint)	Y	N	ARE YOU: 44. presently being treated for any illness	Y	N
11. anemia or other blood disorder	Y	N			
12. prolonged bleeding due to a slight cut	Y	N	46. often exhausted or fatigued	Y	N
13. emphysema	Y	N	47. subject to frequent headaches	Y	N
14. tuberculosis	Y	N	48. a smoker (packs/day)	Y	N
15. asthma	Y	N	50. often unhappy or depressed	Y	N
16. sinus problems	Y	N	51. easily upset or irritated	Y	N
17. kidney disease	Y	N	52. FEMALE – taking birth control pills	Y	N
18. liver disease	Y	N	53. FEMALE – pregnant	Y	N
19. jaundice	Y	N	54. MALE – have prostate disorders	Y	N

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment_____

List any medications taken within the last two years_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY

OR ANY MEDICATIONS YOU MAY BE TAKING

Patient Signature_____Date_____

Doctor's Remarks_____Doctor's Signature_____