

MEDICAL INFORMATION

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient Address _____ Phone _____

Employer Name _____ Phone _____

Medical Doctors Name: _____ General Dentist Name: _____

Please Check all that apply:

Do you have a medical condition that requires you to have antibiotic premedication prior to dental procedures? yes or no
Do you now or have your ever taken medication for osteoporosis? yes or no

List medications you take (including aspirin & supplements): _____

Are you allergic to any medications? List _____ latex allergy? yes no

Are you under the care of a physician? Explain: _____

Have you be admitted to the hospital or been seriously ill in the last five years? Explain _____

Are you pregnant? yes or no

Are you breast feeding? yes or no

Do you take birth control medication? yes or no

Health problems that need further clarification. Explain _____

Do you use tobacco products? yes or no Circle those that you use. Cigarettes Cigars Chewing tobacco Snuff

Do you or a family member have diabetes? yes or no Who? _____

Do you have or have you ever had any of the following: (please circle your answer.)

Aids	yes no	Heart Valve	yes no
Allergies	yes no	Hepatitis (jaundice)	yes no
Anemia	yes no	High Blood Pressure	yes no
Arthritis	yes no	Kidney Disease	yes no
Asthma	yes no	Liver disease	yes no
Cancer or tumor	yes no	Prosthetic Hip	yes no
Chemotherapy	yes no	Rheumatic Fever	yes no
Chest pains (angina)	yes no	Sinus Problems	yes no
Cortisone/steroids	yes no	Shortness of Breath	yes no
Diabetes	yes no	Stomach/intestinal Disease	yes no
Drug reactions	yes no	Stroke	yes no
Epilepsy (adverse)	yes no	Tuberculosis/Lung Disease	yes no
Fainting (frequent)	yes no	Ulcer	yes no
Glaucoma	yes no	Venereal Disease	yes no
HIV Positive	yes no	Other (please specify)	yes no
Hay Fever	yes no	Pacemaker	yes no
Heart Disease/Murmur	yes no		

I certify that the above information is correct.

Signature: _____