MEDICAL HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

List any premedication's required by a physician before dental treatment

DURING THE PAST 12 MONTHS HAVE YOU TAKEN ANY OF THE FOLLOWING?		
Antibiotics or sulfa drugs	☐ Yes	☐ No
Anticoagulants (e.g., Coumadin)	☐ Yes	☐ No
High blood pressure medicine	☐ Yes	☐ No
Tranquilizers	☐ Yes	☐ No
Insulin, Orinase, or similar drug	☐ Yes	☐ No
Cortisone (steroids)	☐ Yes	☐ No
Nonprescription drug/supplements	☐ Yes	☐ No

HEALTH HISTORY

Do you have or have you ever had:

☐ Chest/Heart problems	☑ Special Diet	☐ Lumps/Swelling in the Mouth
☐ Shortness of Breath	☑ Constipation/Diarrhea	☐ Jaundice
☐ Blood Pressure – High/Low	☐ Kidney	☐ Hepatitis
☐ Heart Murmur	☑ Bladder	☐ Liver Trouble
☐ Heart Valve	☑ Bone/Joint	☐ Herpes or other STD
☐ Heart Medication	☐ Arthritis	☐ HIV-positive/AIDS
☐ Rheumatic Fever	☐ Back/Neck Pain	☐ Glaucoma
☐ Pacemaker	☐ Strokes	☐ Contact Lenses
☐ Artificial Heart Valve	☐ Frequent/Severe Headaches	☐ Other pain/discomfort:
☐ Circulation/Blood	☐ Thyroid	
☐ Easy Bruising	☐ Persistent Cough/Swollen Glands	
☐ Abnormal Bleeding	☐ Fainting	
☐ Blood Disease (anemia)	☐ Seizures	
☐ Blood Transfusion	☐ Epilepsy	
☐ Intestinal	☐ Cancer/Tumor	
☐ Ulcers	☐ Chemotherapy, Immunosuppressive Medication	
☐ Weight Gain/Loss	☐ Radiation Therapy	

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Are you allergic, or have you reacted adversely to any of the following?

☐ Local anesthetics	☐ Aspirin, Acetaminophen, or Ibuprofen
☐ Penicillin or other antibiotics	☐ Codeine, Demerol, or other narcotics
☐ Sulfa drugs	☐ Reaction to metals
☐ Barbiturates, sedatives, or sleeping pills	☐ Latex or rubber dam
☐ Other:	

HEALTH HABITS

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	How many drinks per week?		
	History of alcohol abuse?		
Drugs	Do you smoke?	☐ Yes	☐ No
	History of drug abuse?		

WOMEN ONLY

Are you pregnant or breastfeeding?	☐ Yes	☐ No
Are you taking contraceptives or other hormones?	☐ Yes	☐ No

Print Name **Patient/Parent Signature** **Date**

Submit