MEDICAL HISTORY...

Are you in good health? ❑ Yes ❑ No • Height _____ Weight _____ • Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Have you ever had general anesthesia? ❑ Yes ❑ No • Have you, or a family member, had any unusual or serious reactions to general anesthesia? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Mental health problems	❑	❑	Bleeding tendency	❑	❑	Sexually transmitted diseases
❑	❑	High blood pressure	❑	❑	Problems with immune system	❑	❑	Blood transfusion	❑	❑	Contagious diseases
❑	❑	Low blood pressure			*(possibly from med. / surg.)*	❑	❑	Blood disorder	❑	❑	Infectious mononucleosis
❑	❑	Mitral valve prolapse	❑	❑	Delay in healing	❑	❑	Bruise easily	❑	❑	Swollen ankles
❑	❑	Heart murmur	❑	❑	Hay fever / Sinus problems	❑	❑	Eye disease / Glaucoma	❑	❑	Arthritis / Joint disease
❑	❑	Chest pain / Angina	❑	❑	Snoring	❑	❑	Jaundice / Liver disease	❑	❑	Prosthetic implant
❑	❑	Heart attack(s)	❑	❑	Sleep apnea / CPAP	❑	❑	Hepatitis	❑	❑	Joint replacement
❑	❑	Irregular heart beat	❑	❑	Respiratory problems	❑	❑	Gallbladder trouble	❑	❑	Osteoporosis / Osteopenia
❑	❑	Cardiac pacemaker	❑	❑	Tuberculosis	❑	❑	Fainting spells	❑	❑	Osteonecrosis
❑	❑	Heart surgery	❑	❑	Emphysema	❑	❑	Convulsions / Epilepsy	❑	❑	Stomach ulcers
❑	❑	Damaged heart valves	❑	❑	Do you smoke	❑	❑	Stroke	❑	❑	GI troubles / IBS / Colitis
❑	❑	Pneumonia / Bronchitis / Chronic cough			*If so, # packs a day*_____	❑	❑	Thyroid trouble	❑	❑	Tumor or growth
❑	❑	Chronic fatigue / Night sweat	❑	❑	Do you use chewing tobacco	❑	❑	Diabetes	❑	❑	Cancer / Radiation / Chemotherapy
❑	❑	Trouble climbing 1-2 flights of stairs	❑	❑	A history of drug abuse	❑	❑	Low blood sugar	❑	❑	Are you on a diet
❑	❑	Anemia	❑	❑	A history of alcohol abuse	❑	❑	Are you on dialysis	❑	❑	Contact lenses
❑	❑	Asthma	❑	❑	Abnormal bleeding	❑	❑	Kidney trouble			

MEDICATION & ALLERGIES...

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
									❑	❑	Blood thinners (Coumadin,Aspirin)
									❑	❑	Are you taking, or have you ever taken, any bone density meds. or bisphosphonates, such as Fosamax, Boniva, Actonel, IV Zometa, Reclast, Xgeva, Prolia, or Aredia within the past 12 years.

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Amoxicillin
❑	❑	Sodium pentothal / Valium / other tranq.	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites	❑	❑	**Do you have any known allergies**

Please list any other medication or antibiotic you are allergic to:

MEDICATION / ANTIBIOTIC NAME	MEDICATION / ANTIBIOTIC NAME

Please list any allergies other than drug allergies:

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No
2) Expected delivery date: _____
3) Are you nursing? ❑ Yes ☑ No
4) Are you taking birth control pills: ❑ Yes ❑ No