MEDICAL INFORMATION

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. When was your last **MEDICAL** checkup? _____

2. Has there been any change in your general health in the past year? If yes, please explain.

   ❒ YES ❒ NO _____

3. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

   ❒ YES ❒ NO _____

4. Are you taking any medications, non-prescription *drugs* or herbal supplements of any kind? If yes, please list names of medications.

   ❒ YES ❒ NO _____
   _____

5. Do you have any allergies? If you answered yes, please list using the categories below: ❒ YES ❒ NO

   a) medications _____
   b) latex/rubber products _____
   c) other, e.g hay fever, foods _____

6. Have you ever had a peculiar or adverse reaction to any medications or injections? If yes, please explain.

   ❒ YES ❒ NO _____

7. Do you have or have you ever had any heart or blood pressure problems? If yes, please list.

   ❒ YES ❒ NO _____

8. Do you have a prosthetic or artificial joint? ❒ YES ❒ NO

   If **Yes**, have you ever been advised by your doctor to take premedication (antibiotics) before dental treatment?

   ❒ YES ❒ NO

9. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy).

   ❒ YES ❒ NO _____

10. Have you ever had hepatitis, jaundice or liver disease?

    ❒ YES ❒ NO

11. Do you have a bleeding problem or bleeding disorder?

    ❒ YES ❒ NO _____

12. Have you ever been hospitalized (in last 5 years) for any illness or operations? If yes, please explain.

    ❒ YES ❒ NO _____

13. Do you have or have you ever had any of the following? Please check.

❒ arthritis	❒ pacemaker
❒ asthma	❒ prosthetic heart valve
❒ cancer	❒ seizures (Epilepsy)
❒ chest pain, angina	❒ shortness of breath
❒ diabetes	❒ steroid therapy
❒ diet pill therapy	❒ stomach ulcers
❒ heart attack	❒ stroke
❒ kidney disease	❒ thyroid disorder
❒ heart murmur	❒ mitral valve prolapse
❒ rheumatic fever	❒ other – please list below

    _____
    _____

14. Do you smoke? ❒ YES ❒ NO

15. Does your jaw crack or pop when opened wide?
    ❒ YES ❒ NO

16. **FOR WOMEN ONLY:** Are you pregnant or breastfeeding? If pregnant, what is the expected delivery date?

    ❒ YES ❒ NO _____.

In order to avoid complications as a result of a change in your medical condition, it is important you notify this office of any change.

_____ _____

SIGNATURE *DATE*

_____

NAME (PRINTED)