

**Medical History**

Name: Date:

1. Are you now under the care of a physician? Yes\_\_\_ No\_\_\_
2. If so, what is the condition being treated?
3. Have you had any serious illness or operation? Yes\_\_\_ No\_\_\_
4. Do you have any artificial heart valves, heart defects, hip joints, etc.? Yes\_\_\_ No\_\_\_
5. Do you have or have you ever been told you have any of the following diseases or problems?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Cardiovascular disease (heart trouble,  heart attack, coronary insufficiency, arteriosclerosis, stroke) |  |  |  | High cholesterol | Yes\_\_\_ | No\_\_\_ |
| Yes\_\_\_ | No\_\_\_ |  | Diabetes, which type?\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes\_\_\_ | No\_\_\_ |
| Heart Murmur | Yes\_\_\_ | No\_\_\_ |  | Hepatitis | Yes\_\_\_ | No\_\_\_ |
| Mitral Valve Prolapse | Yes\_\_\_ | No\_\_\_ |  | Jaundice or liver disease | Yes\_\_\_ | No\_\_\_ |
| High Blood Pressure | Yes\_\_\_ | No\_\_\_ |  | Arthritis | Yes\_\_\_ | No\_\_\_ |
| Rheumatic heart disease | Yes\_\_\_ | No\_\_\_ |  | Stomach ulcers | Yes\_\_\_ | No\_\_\_ |
| Asthma | Yes\_\_\_ | No\_\_\_ |  | Tuberculosis | Yes\_\_\_ | No\_\_\_ |
| Fainting spells or seizures | Yes\_\_\_ | No\_\_\_ |  | HIV Positive | Yes\_\_\_ | No\_\_\_ |
| Sleep apnea | Yes\_\_\_ | No\_\_\_ |  | Thyroid trouble | Yes\_\_\_ | No\_\_\_ |
| Kidney trouble | Yes\_\_\_ | No\_\_\_ |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

1. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes\_\_\_ No\_\_\_
2. Have you ever required a blood transfusion? Yes\_\_\_ No\_\_\_
3. If so, when?
4. Do you have a blood disorder such as anemia? Yes\_\_\_ No\_\_\_
5. Are you taking any of the following drugs or medicines?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Antibiotics or sulfa drugs | Yes\_\_\_ | No\_\_\_ |  | Tranquilizers or sedatives | Yes\_\_\_ | No\_\_\_ |
| Anticoagulants (blood thinners) | Yes\_\_\_ | No\_\_\_ |  | Digitalis or drugs for heart trouble | Yes\_\_\_ | No\_\_\_ |
| Medicine for high blood pressure | Yes\_\_\_ | No\_\_\_ |  | Medicine for osteoporosis/cancer | Yes\_\_\_ | No\_\_\_ |
| Cortisone (steroids) | Yes\_\_\_ | No\_\_\_ |  | Others:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes\_\_\_ | No\_\_\_ |
| Insulin, tolbutamide (Orinase), or similar drug | Yes\_\_\_ | No\_\_\_ |  | Others:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes\_\_\_ | No\_\_\_ |
| Aspirin | Yes\_\_\_ | No\_\_\_ |  | Others:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes\_\_\_ | No\_\_\_ |

1. Have you ever taken medication for osteoporosis? If so, when did you stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes\_\_\_ No\_\_\_
2. Are you allergic or have you reacted adversely to:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Local anesthetics (“Novocaine”) | Yes\_\_\_ | No\_\_\_ |  | Aspirin | Yes\_\_\_ | No\_\_\_ |
| Penicillin | Yes\_\_\_ | No\_\_\_ |  | Latex | Yes\_\_\_ | No\_\_\_ |
| Other antibiotics | Yes\_\_\_ | No\_\_\_ |  | Codeine | Yes\_\_\_ | No\_\_\_ |
| Sulfa drugs | Yes\_\_\_ | No\_\_\_ |  | Others:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes\_\_\_ | No\_\_\_ |
| Barbiturates, sedatives, or sleeping pills | Yes\_\_\_ | No\_\_\_ |  |  |  |  |

1. Do you have any disease, condition or problem not listed above that you think we should know about? Yes\_\_\_ No\_\_\_
2. For women, are you pregnant? Yes\_\_\_ No\_\_\_

To the best of my knowledge, I have answered all parts completely and accurately. I will inform my doctor of changes in my health or medications.

X Reviewed by:

Signature of Patient or Responsible Party