

8. Medical History

Are you currently or within the past two years been under the care of a physician? Yes No

Why? _____

List previous hospitalizations/illnesses: _____

List all previous surgeries: _____

List all prescription/over-the-counter medications: _____

Have you ever been given antibiotics prior to dental visits? Yes No

Do you drink alcohol? (circle one) Never Occasionally Weekends Daily

Do you use recreational drugs or have a past history of drug abuse? Yes No

Are you allergic to: (circle) Penicillin Codeine Hydrocodone Dental Anesthetic Metals Latex

Cephlasporins Erythromycin Aspirin Ibuprofen Sulfa Other _____

Do you require antibiotics prior to dental work? Yes No Why? _____

Have you ever taken Fosomax or other like medicine to treat osteoporosis? Yes No

Do you have or have you ever had any of the following? (circle any that apply)

- | | |
|---------------------------|-------------------------|
| Heart Disease | Head Injury |
| Heart attack | Stroke/TIA |
| Chest pain | Sinus disease/surgery |
| Rheumatic fever | Lung disease |
| Heart murmur | Asthma |
| Cardiac pacemaker | Difficulty breathing |
| Artificial heart valve | Steroids/prednisone |
| Mitral valve prolapse | Epilepsy or seizures |
| Abnormal blood pressure | Hepatitis |
| Ulcer | Kidney disorder |
| Blood disease or disorder | Venereal disease |
| Blood transfusion | AIDS or HIV positive |
| Diabetes | Chemo/radiation therapy |
| Artificial joints | Immune system disorder |
| Substance abuse | Psychiatric therapy |
| Osteoporosis | Arthritis |
| Hiatal hernia | Glaucoma |

Any other medical or health concerns that the dentist should be aware of? What? _____

For Women:
 Are you taking birth control pills? Yes No (Some antibiotics may interfere with efficacy)
 Are you pregnant or is there a chance you may be pregnant? Yes No Week # _____
 Are you nursing? Yes No

Updates _____

