

Medical Information

Name: _____ Sex: M / F

Date of Birth: ____ / ____ / ____ Occupation: _____

Physician name & Phone number: _____

Pharmacy name & Phone number: _____

Check all that apply (past & present):

Allergy to: __ Penicillin or other antibiotics __ Codeine or narcotics __ Latex
 __ Other medication(s) _____ __ Local Anesthetics __ Metals

Cardiac Condition(s):
 __ Rheumatic Heart Disease __ Heart Murmur / Mitral Valve Prolapse
 __ Artificial Heart Valve(s) __ Congenital Heart Disease / Defect
 __ Shunt / Conduit __ Pacemaker
 __ Hypertension __ Previous Bacterial Endocarditis
 __ Angina __ Other (specify) _____

- | | |
|---|--|
| <input type="checkbox"/> Pregnant or nursing | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Antibiotic Prophylaxis for dental procedures | <input type="checkbox"/> Artificial Joint Replacement |
| <input type="checkbox"/> Cancer / Chemotherapy / Radiation Treatment | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Immunosuppression / Corticosteroid Treatment | <input type="checkbox"/> Hemodialysis |
| <input type="checkbox"/> Anti-Coagulant Therapy | <input type="checkbox"/> Blood Disease / Disorder |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> G.E. Reflux |
| <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Mental Health Disorder |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Tobacco use (smoking, snuff, chew) | <input type="checkbox"/> Alcohol / Chemical dependency |

List all other medical conditions, illnesses, operations, or hospitalizations not indicated above:

List all medication(s) currently taken and corresponding medical conditions: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take because of errors or omissions that I may have made in the completion of this form.

Date Signature of Patient / Legal Guardian (relationship)

Date Signature of Dentist Comments / Updates

