



# Medical Form

To serve you properly we will need the following information. All information will be strictly confidential. Please print.

## Current Medical Condition

1. 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  Not Sure/Maybe

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2. When was your last medical checkup?

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3. Has there been any change in your general health in the past year? If yes, please explain.  Yes  No  Not Sure/Maybe

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4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?  Yes  No  Not Sure/Maybe

If yes, please list.

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5. Do you have any allergies?  Yes  No  Not Sure/Maybe

If yes, please list using categories below:

a) medications:

b) Latex/rubber products:

c) Other (e.g. hayfever, foods):

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6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.  Yes  No  Not Sure/Maybe

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7. Do you have or have you ever had asthma?  Yes  No  Not Sure/Maybe

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8. Do you have or have you ever had blood pressure problems?  Yes  No  Not Sure/Maybe

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9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart, a heart condition from birth or a heart transplant?  Yes  No  Not Sure/Maybe

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10. Do you have a prosthetic or artificial joint?  Yes  No  Not Sure/Maybe

11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?)  Yes  No  Not Sure/Maybe

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12. Have you ever had hepatitis, jaundice or liver disease?  Yes  No  Not Sure/Maybe

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13. Do you have a bleeding problem or bleeding disorder?  Yes  No  Not Sure/Maybe

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14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.  Yes  No  Not Sure/Maybe

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

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|--|--|--|--|--|
| <input type="checkbox"/> Chest pain, angina      | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Pacemaker                                       | <input type="checkbox"/> Steroid therapy | <input type="checkbox"/> Seizures (epilepsy)   |
| <input type="checkbox"/> Heart attack            | <input type="checkbox"/> Lung disease    | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Kidney disease  |  |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Stomach ulcers  | <input type="checkbox"/> Cancer  | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Heart murmur    | <input type="checkbox"/> Tuberculosis                                    | <input type="checkbox"/> Arthritis       |  |
| <input type="checkbox"/> Drug/alcohol dependency |  | <input type="checkbox"/> Osteoporosis medications (e.g. Fosamax Actonel) |  |  |
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16. Are there any conditions or diseases not listed above that you have or have had? If so, please list.  Yes  No  Not Sure/Maybe

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17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)  Yes  No  Not Sure/Maybe

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18. Do you smoke or chew tobacco products?  Yes  No  Not Sure/Maybe

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19. **For women only:** Are you breastfeeding or pregnant?  Yes  No  Not Sure/Maybe  
If pregnant, what is the expected delivery date?

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*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any change in my health or medication.*

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_ Date: \_\_\_\_\_