NAME: _____ DATE: _____

Name of Dentist: _____ **Name of Physician:** _____

MEDICAL/DENTAL HISTORY:

1. **PLEASE CHECK IF EITHER APPLIES:** ___ **LATEX ALLERGY**
   ___ **PRE-MEDICATE** with Antibiotics for Prosthetic Joint or Heart Condition?
   Reason: _____ Medication: _____

2. **Are you now or have you been treated for any serious illness or condition?**
   YES ____ NO____ EXPLAIN: _____

3. **Have you ever had an unfavorable reaction following dental treatment?**
   YES ____ NO____ EXPLAIN: _____

4. **Do you have, or have you had any of the following?**

YES	NO		YES	NO		YES	NO	
___	___	Prosthetic Joint Replacement	___	___	Respiratory Problems	___	___	Osteoporosis
___	___	Heart Valve Problem	___	___	Asthma or Hay Fever	___	___	Blood Transfusion
___	___	Heart Murmur	___	___	Sinus Trouble	___	___	Prolonged Bleeding
___	___	Irregular Heart Beat	___	___	Lung Disease	___	___	Blood Disease
___	___	Heart Problems	___	___	Tuberculosis	___	___	Cancer/Tumor: _____
___	___	High/Low Blood Pressure	___	___	Hepatitis or Liver Disease	___	___	Radiation Treatment
___	___	Chest Pain	___	___	Thyroid Disease	___	___	Mental/Nervous Disorder
___	___	Pacemaker	___	___	Diabetes – Type _____	___	___	Venereal Disease/Herpes
___	___	Stroke	___	___	Glaucoma	___	___	HIV or AIDS
___	___	Fainting Tendency	___	___	Kidney/Bladder Trouble	___	___	Chemical Dependency
___	___	Epilepsy/Seizures	___	___	Ulcers	___	___	MRSA

5. **During the past 12 months have you taken any of the following?**

YES	NO		YES	NO		YES	NO	
___	___	Blood Thinners	___	___	Insulin	___	___	Tranquilizers/Sedatives
___	___	Nitroglycerin	___	___	Phen/Phen	___	___	Birth Control Pills
___	___	High BP Meds_____	___	___	Bisphosphonates (Zometa/Aredia/Fosamax)			

6. **List ALL Medications that you are CURRENTLY taking and indicate what condition the medication is being used to treat/address:**

Medication: _____ For: _____ Medication: _____ For: _____
Medication: _____ For: _____ Medication: _____ For: _____
Medication: _____ For: _____ Medication: _____ For: _____
Medication: _____ For: _____ Medication: _____ For: _____

7. **Have you had an ALLERGIC REACTION or Sensitivity to any of the following?**

YES	NO		YES	NO		YES	NO	
___	___	Latex	___	___	Flagyl/Metronidazole	___	___	Ibuprofen/Advil/Motrin
___	___	Penicillin/Amoxicillin	___	___	Hydrocodone/Vicodin	___	___	Tylenol
___	___	Clindamycin	___	___	Codeine	___	___	Dental Anesthesia
___	___	Keflex/Cephalexin	___	___	Aspirin			

* **OTHER ALLERGIES**: _____

8. **Do you clench or grind your teeth?** YES ___ NO ___ Explain: _____

9. **Women Only:** Are you Pregnant? YES___ NO___ How many Months? _____

The Above Information is true and to the best of my knowledge.

SIGNATURE _____ **DATE:** _____