barkley village family dentistry

Medical History

Patient name _____ Age _____

Name of physician _____

Date of last physical examination _____

Purpose _____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

Check if you have, or ever had the following:

Allergic reaction to:

- ☐ aspirin
- ☐ penicillin
- ☐ erythromycin
- ☐ codeine
- ☐ dental anesthetics
- ☐ any other medications _____
- ☐ Latex
- ☐ Iodine
- ☐ fluoride
- ☐ metals (gold, stainless steel)

- ☐ hospitalization for illness or injury
- ☐ heart problems
- ☐ heart murmur
- ☐ rheumatic fever
- ☐ scarlet fever
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ a stroke
- ☐ artificial prosthesis (i.e. heart valve or joints)
- ☐ anemia or other blood disorder
- ☐ excessive prolonged bleeding with slight cut (hemophilia)
- ☐ emphysema
- ☐ tuberculosis
- ☐ asthma
- ☐ sinus problems
- ☐ diabetes.
- ☐ kidney disease
- ☐ liver disease
- ☐ jaundice
- ☐ thyroid or parathyroid disease
- ☐ stomach or duodenal ulcer
- ☐ cancer
- ☐ arthritis
- ☐ glaucoma
- ☐ contact lenses
- ☐ head or neck injuries
- ☐ epilepsy, convulsions (seizures)
- ☐ viral infections and cold sores
- ☐ any lumps or swelling in the mouth
- ☐ hives, skin rash, hay fever
- ☐ venereal disease
- ☐ hepatitis (type_____)
- ☐ aids ☐ hiv positive
- ☐ tumor, abnormal growth
- ☐ radiation therapy
- ☐ emotional problems
- ☐ psychiatric treatment
- ☐ antidepressant medication
- ☐ alcohol/drug dependency
- ☐ presently being treated for any illness
- ☐ aware of a change in your general health
- ☐ often exhausted or fatigued
- ☐ subject to frequent headaches
- ☐ do you use tobacco
- ☐ heavy coffee drinker
- ☐ heavy soda pop drinker
- ☐ generally a nervous person
- ☐ often unhappy or depressed
- ☐ FEMALE - taking birth control pills
- ☐ FEMALE - pregnant
- ☐ MALE - Prostate disorders
- ☐ bone density medication, past or current
- ☐ blood thinner medication, past or current

Has it ever been recommended that you take antibiotics prior to dental treatment? ☐ Yes ☐ No

Please describe any current medical treatment, impending surgery, or other recommended treatment that has not been completed

_____

List all current medications _____

_____

List any medications taken within the last two years _____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Patient's Signature _____ Date _____

MEDICAL HISTORY REVIEW	DATE	INITIAL