reardon DENTISTRY

Patient _____ Birth Date _____

MEDICAL HISTORY

1. Physician _____ Address _____

2. When was your last physical examination? _____

3. Are you under the care of a physician? ◯ Yes ◯ No If yes, for what reason(s)?: _____

_____

4. Have you had any other serious illness, hospitalization or accident? ◯ Yes ◯ No

If yes, please explain: _____

_____

_____

5. (Women) Are you pregnant? ◯ Yes ◯ No If yes, how long? _____

6. Are you allergic/sensitive to: ◯ Penicillin ◯ Codeine ◯ Local Anesthetic ◯ Latex ◯ None

◯ Other _____

7. Do you have, or have you ever had:

Heart trouble	◯ Yes	◯ No	Excessive or prolonged bleeding	◯ Yes	◯ No
Heart murmur	◯ Yes	◯ No	Fainting spells	◯ Yes	◯ No
Heart surgery	◯ Yes	◯ No	Jaundice	◯ Yes	◯ No
Heart pacemaker	◯ Yes	◯ No	Hepatitis (Type _____)	◯ Yes	◯ No
Rheumatic fever	◯ Yes	◯ No	Asthma	◯ Yes	◯ No
Congenital heart defects	◯ Yes	◯ No	Sinus trouble	◯ Yes	◯ No
Abnormal blood pressure	◯ Yes	◯ No	Cancer	◯ Yes	◯ No
Ulcers	◯ Yes	◯ No	Chemotherapy/Radiation	◯ Yes	◯ No
Tuberculosis or lung disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	Hearing impaired	◯ Yes	◯ No
Epilepsy	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Psychiatric care	◯ Yes	◯ No
Thyroid problem	◯ Yes	◯ No	Prosthetic implant	◯ Yes	◯ No
Chemical dependency	◯ Yes	◯ No	Venereal disease	◯ Yes	◯ No
Arthritis	◯ Yes	◯ No	Oral herpes lesions	◯ Yes	◯ No
			HIV positive/AIDS	◯ Yes	◯ No

8. Do you smoke? ◯ Yes ◯ No If yes, how much? _____

9. Do you chew tobacco? ◯ Yes ◯ No

10. Are you presently taking any medication/drugs/pills? ◯ Yes ◯ No If yes, please list: _____

_____

_____

_____

11. Have you ever been required to take an antibiotic before dental treatment? ◯ Yes ◯ No

Patient Signature _____ Date _____