Medical History – Confidential Name_____Date_____DOB_____

1. Describe your present health ___Excellent ___Good___Fair___Poor

2. Current physicians

_____Type: _____

_____Type: _____

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ASA: I II III IV

3. Have you ever seen a cardiologist ? Y / N When: _____ Why:_____
4. Have you ever had heart testing or an EKG? Y / N Findings: _____
5. Any significant changes to your health or surgeries/hospitalizations in the past 2 years? Y / N
   Please note: _____
6. Do you take antibiotics prior to **every** dental appointment for **premedication**? Y / N **If yes**, was it taken today? Y / N
   If yes, What do you usually take for pre-med?_____

7. **Please indicate which of the following you have had or currently have:**

Heart trouble or illness	Y / N	Lung problems	Y / N	Tumors	Y / N	Immunosupressive disorders	Y / N
Heart attack_____	Y / N	Asthma	Y / N	Cancer	Y / N	Autoimmune disorders	Y / N
Heart surgery_____	Y / N	Is rescue inhaler with you?		Chemotherapy	Y / N	(i.e. Lupus, Epstein Barr, Rheumatoid Arthritis)	
Heart valve surgery	Y / N	_____		Radiation therapy	Y / N	Infectious diseases or STDs	Y / N
Artificial valve	Y / N	Emphysema	Y / N	Endocrine Problems	Y / N	HIV+ or AIDS	Y / N
Heart murmer	Y / N	Chronic cough	Y / N	Diabetes I II	Y / N	Viral load_____CD4 count_____	
Mitral valve prolapse	Y / N	Tuberculosis	Y / N	BGL_____ Last meal _____		Cold sores/fever blisters	Y / N
Damaged heart valve	Y / N	Sinus trouble	Y / N	Last HA1C_____ When_____		Epilepsy or Seizures	Y / N
Congenital heart disease	Y / N	Acid Reflux/ GERD	Y / N	Thyroid problems	Y / N	Fainting or dizzy spells	Y / N
Congestive heart failure	Y / N	Liver disease	Y / N	Steriods/cortisone meds	Y / N	Psychiatric / Psychological care	Y / N
Rheumatic fever	Y / N	Hepatitis	Y / N	Can you take NSAIDS?	Y / N	Depression / Anxiety	Y / N
Rheumatic heart disease	Y / N	A B C		(i.e.Ibuprofen/Advil, not Tylenol)		Dementia/Alzheimer's disease	Y / N
Blood transfusion	Y / N	Jaundice	Y / N	Ulcers	Y / N	Recreational drug use	Y / N
Stroke/TIAs	Y / N	Kidney problems	Y / N	Metal implants (pins / rods)	Y / N		
Bleeding disorder	Y / N	_____		**Joint replacement**	Y / N →	**If yes,when/what**_____	
High blood pressure	Y / N	Glaucoma	Y / N	**Osteoporosis** (bone loss)	Y / N		
High cholesterol	Y / N	Narrow or open angle		**Have you ever taken bisphosphonates (IV / Oral)?**	Y / N	(i.e. Boniva/Fosamex)	
Angina	Y / N	Hearing loss	Y / N	Medication_____	When/how long?_____		

8. Have you had any other illnesses, diseases, operations, conditions not listed above? Y / N (Please list if yes):
   _____
9. Have you ever been turned down as a blood donor? Y / N _____
10. Have you ever taken medications for weight loss? Y / N _____If yes, did you take Fen-Phen (Fenfluramine-Phentermine)? Y / N
11. Do you use tobacco? Y / N Type (Please circle): Cigarettes / Cigars / Chewing Tobacco / Snuff **How much?_____ How long? _____**
    Are you interested in quitting? Y / N
12. Have you ever served in the military? Y / N When & Where?_____
13. Are you allergic or have had an adverse reaction to any drugs or medications? Y / N
    Please list: _____
14. Are you sensitive or allergic to latex? Y / N _____

15. ***Women:*** Are you Pregnant? Y / N How many weeks?_____ Are you Nursing? Y / N Are you using Birth Control? Y / N Type:_____
    ******Some medications can interfere with your baby's development and antibiotics can affect oral contraceptive efficacy.******

Current medications/supplements: (prescription and over-the-counter)

Name	**Dosage/frequency**	**Reason for taking**

To the best of my knowledge, all the preceding answers are true and correct. If I have any changes in my health or medicines, I will inform my doctor at or before my next appointment.

Patient/Guardian Signature_____**Date**_____