PATIENT MEDICAL HISTORY

1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, explain in the box below: ○ Yes ○ No ○ Unknown

2. Has there been any change in your general health within the past year? If yes, explain in the box below: ○ Yes ○ No ○ Unknown

3. Are you under the care of a physician for a current problem? If yes, explain in the box below: ○ Yes ○ No ○ Unknown

4. Have you been hospitalized within the past 5 years? If yes, specify in the box below: ○ Yes ○ No ○ Unknown

5. Have you received therapy for alcoholism or drug addiction during the past 5 years? ○ Yes ○ No ○ Unknown

6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics, antibiotics or medications? Enter notes if needed in the box below: ○ Yes ○ No ○ Unknown

7. Is there any condition concerning your health that the doctor should be told? ○ Yes ○ No ○ Unknown

8. Do you wish to speak to the doctor privately about anything? ○ Yes ○ No ○ Unknown

9. Have you had abnormal bleeding with previous extraction's, surgery, or trauma? ○ Yes ○ No ○ Unknown

10. Have you ever required a blood transfusion? ○ Yes ○ No ○ Unknown

11. Have you ever had radiation for any condition? ○ Yes ○ No ○ Unknown

12. Have you ever tested positively for HIV infection or AIDS? If so state date diagnosed and treating Dr. ○ Yes ○ No ○ Unknown

13. Before a dental appointment are you required to take premedication? ○ Yes ○ No ○ Unknown

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

- ☐ High blood pressure
- ☐ Heart murmur or prolapsed valve
- ☐ Joint prosthesis (hip, knee, etc.)
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Sinus trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach ulcers, colitis
- ☐ Hepatitis, jaundice, liver disease