Medical History Form

Name (please print): ____________________

Signature: ____________________ Date: ____________________

General Information

For each, please check the correct response:

Do you need antibiotic premedication before dental work?
___ Yes ___ No

What is your current physical health?
___ Good ___ Fair ___ Poor

Are you currently under the care of a physician?
___ Yes ___ No

Do you use tobacco in any form?
___ Yes ___ No

Are you—or could you be—pregnant?
___ Yes ___ No

If yes, please indicate approximate Week #,
if known: _________

Allergies

Please check if you are allergic to any of the following:

___ Anesthetics
___ Aspirin
___ Codeine
___ Erythromycin
___ Jewelry
___ Latex
___ Penicillin
___ Sedatives
___ Sulfa
___ Tetracyclines
___ No known allergies
___ Other drug allergy (please specify)

____

Medications

Please check all medications or drugs you are currently taking:

___ Acetaminophen
___ Antibiotics
___ Antihistamines
___ Aspirin
___ Blood Thinners
___ Blood Pressure
___ Cold/Sinus
___ Heart Medication
___ Insulin/Diabetic
___ Nitroglycerin
___ Steroids/Cortisone
___ Thyroid
___ Tranquilizers
___ Recreational Drugs
___ Other medications and/or drugs (please specify)

____

Medical Conditions / Diseases

Please check any of these you have had or are presently experiencing. For any conditions indicated, please provide additional information below or on back. Thank you.

___ No known medical conditions
___ Abnormal Bleeding
___ Alcohol Abuse
___ Anemia
___ Arthritis
___ Artificial Joints
___ Artificial Valves
___ Asthma
___ Blood Transfusion
___ Cancer
___ Chemotherapy
___ Colitis
___ Congenital Heart Defect
___ Diabetes
___ Difficulty Breathing
___ Drug Abuse
___ Emphysema
___ Epilepsy
___ Fainting Spells
___ Glaucoma
___ Hay Fever
___ Heart Attack
___ Heart Murmur
___ Heart Surgery
___ Hemophilia
___ Hepatitis
___ Herpes/Fever Blisters
___ High Blood Pressure
___ HIV+/AIDS
___ Hospitalization for Any Reason
___ Kidney Problems
___ Liver Disease
___ Low Blood Pressure
___ Lupus
___ Mitral Valve Prolapse
___ Osteoporosis
___ Pacemaker
___ Persistent Cough
___ Psychiatric Problems
___ Radiation Treatment
___ Rheumatic Fever
___ Seizures
___ Severe Headaches
___ Sinus Problems
___ Steroid Therapy
___ Stroke
___ Thyroid Problems
___ Tuberculosis (TB)
___ Ulcers
___ Venereal Disease
___ Other (please specify)

Additional Information or Other Concerns

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Morningside Dental