## **Medical History Form**

Emergency Contact Relationship  DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS  Active Tuberculosis  MEDICAL HISTORY  Are you now under the care of a physician?  Physician Name  Are you in good health?  YESO  NO  Ary change in your health within the past year?  Are you had a serious illness or been hospitalized in the past 5 years?  YESO  NO  Are you had a serious illness or been hospitalized in the past 5 years?  YESO  NO  Are you had a serious illness or been hospitalized in the past 5 years?  YESO  NO  If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements  Have you had any orthopedic total joint replacement?  Have you had any orthopedic total joint replacement?  YESO  NO  Do you use controlled substances (drugs)?  YESO  NO  Do you use controlled substances (drugs)?  YESO  NO  Number of weeks  Taking Birth control pills?  ALERGIES, ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTION TO  Olocal anesthetics  Near you had any of the past year?  Allergies, ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTION TO  Allergian or other antibiotics  Near you had any of the past year?  Are you taking sint control pills?  Allergian or other antibiotics  Near you had any of the past year?  Are you taking sint or other antibiotics  Apairin  Are you taking sint or other antibiotics  Apairin  Are you taking sint years years years years years years years years years?  Are you taking sint years	Emergency Contact									11	
DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS  Active Tuberculosis  Persistent cough greater than a 3 week duration  Been exposed to anyone with Tuberculosis Been exposed to anyone with Tubercu	Emergency Contact Phone						Precision Dental				
Are you now under the care of a physician? Physician Name Are you in good health? Are you but a serious illness or been hospitalized in the past 5 years? Are you taking or have you recently taken any prescription or over the counter medicine(s)?  If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements  Have you had any orthopedic total joint replacement?  Are you taking or have you recently taken any prescription or over the counter medicine(s)?  Have you had any orthopedic total joint replacement?  YES	DO YOU HAVE ANY OF THE FOLLOWING D Active Tuberculosis			BLEMS	<b>.</b>	00				osis	
Physician Name Are you in good health? YES NO Any change in your health within the past year? YES NO Are you in good health? YES NO Any change in your health within the past year? YES NO Are you lad a serious illness or been hospitalized in the past 5 years? YES NO NO Are you taking or have you recently taken any prescription or over the counter medicine(s)? YES NO NO Are you taking or have you recently taken any prescription or over the counter medicine(s)? YES NO NO DO you use voluments within the past year? YES NO NO DO you use tobacco? YES NO NO NO DO you use controlled substances (drugs)? YES NO NO DO you use tobacco? YES NO NO NO NOMAN ONLY. Are you:  Pregnant YES NO NO Number of weeks Naking the control pills? YES NO NO Nursing? YES NO NURSING?  Pregnant YES NO NO Number of weeks Naking the control pills? YES NO NURSING?  Pregnant YES NO NO Number of weeks Naking the control pills? YES NO NO Nursing?  AllERGIES, ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTION TO HAVE ANY OF THE FOLLOWING;  Aspirin Codenie or other narcotics Hay fever/seasonal Hay fever/seasonal Hay fever/seasonal Periodic or other antibiotics Negative or sleeping pills Latex (rubber) Food  Chee (please specify):  CORGENITAL HEART DISEASE (CHD) PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING;  Artificial (prosthetic) heart valve Repaired (completely) in the last 6 months Repaired (completely) in the last											
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Have you had a serious illness or been hospitalized in the past 5 years? YES NO Are you taking or have you recently taken any prescription or over the counter medicine(s)?  If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements  Have you had any orthopedic total joint replacement? YES NO DATE Do you use controlled substances (drugs)? YES NO Do you drus alcoholic beverages?  WOMAN ONLY. Are you:  WOMAN ONLY. Are you:  YES NO NUmber of weeks Nursing?  WOMAN ONLY. Are you.  YES NO Number of weeks Nursing?  WOMAN ONLY. Are you.  YES NO Number of weeks Nursing?  WOMAN ONLY. Are you.  WOMAN CONTROLLERGIC TO OR HAVE YOU HAD ANY REACTION TO  Local anesthetics Aspirin  Pencillin or other antibiotics Sedatives or sleeping pills Latex (rubber)  Other (please specify):  Previous infective endocrafitis Previous infective endocrafitis Damaged valves in transplanted heart Congenital Heart DisEASE (CHD) PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING; Artificial (prosthetic) heart valve Previous infective endocrafitis Damaged valves in transplanted heart Congenital heart disease (HID)  OTHER DISEASES AND CONDITIONS - Please indicate if you have had or not had any of the following: Artificial (prosthetic) heart valve Damaged valves in transplanted heart Congenital heart disease AliDs or HIV Artificial congenital heart disease AliDs or HIV Artificial provides Situate Damaged heart valve Damaged h							_		\/F6 <b>(</b>		
Are you taking or have you recently taken any prescription or over the counter medicine(s)?  IF so, please list all, including vitamins, natural or herbal preparations and/or diet supplements    Have you had any orthopedic total joint replacement?	,			•				past year?	YES	NOO	
Have you had any orthopedic total joint replacement?						_			VEC (		
Have you had any orthopedic total joint replacement? YES NO DATE Do you use controlled substances (drugs)? YES NO Do you use tobacco? YES NO Do you use controlled substances (drugs)? YES NO Do you use tobacco? YES NO Do you have lock and you use tobacco? YES NO Do you have lock and you use tobacco? YES NO DO you have lock and you use tobacco? YES NO DO you have lock and you take lock and	- · · · · · · · · · · · · · · · · · · ·		-						YES	NOO	
Do you use controlled substances (drugs)?  YES  NO  Do you use tobacco?  YES  NO  Do you use tobacco?  YES  NO  Do you use tobacco?  YES  NO  NO  NO  NO  NO  NO  NO  NO  NO  N	ir so, please list all, including vitamins, natural or nerbal preparations and/or diet supplements										
Do you use controlled substances (drugs)?  YES  NO  Do you use tobacco?  YES  NO  Do you use tobacco?  YES  NO  Do you use tobacco?  YES  NO  NO  NO  NO  NO  NO  NO  NO  NO  N	Have you had any orthonedic total joint re	nlace	ment?		FS	NO	DΔTF				
Do you drink alcoholic beverages?  WOMMAN ONLY. Are you:  Pregnant  Taking Birth control pills?  ALLERGIES, ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTION TO  Local anesthetics  Aspirin  Pencillin or other antibiotics  Sedatives or sleeping pills  Codeine or other narcotics  Metals  Sedatives or sleeping pills  Latex (rubber)  COMGENITAL HEART DISEASE (CHD) PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING;  Artificial (prosthetic) heart valve  Previous infective endocarditis  Damaged valves in transplanted heart  Congenital heart disease (CHD)  OTHER DISEASES AND CONDITIONS - Please indicate if you have had or not had any of the following:  Cardiovascular disease  AlDS or HIV  Artificial (prosthetic) please indicate if you have had or not had any of the following:  Cardiovascular disease  AlDS or HIV  Artificial prostedics  Autoimmune disease  AlDS or HIV  Artificial prostedics  Autoimmune disease  AlDS or HIV  Thyroid problems  Artificial prostedics  Autoimmune disease  AlDS or HIV  Thyroid problems  Artificial prostedics  Autoimmune disease  AlDS or HIV  Thyroid problems  Artificial prostedics  Autoimmune disease  Glaucoma  Heart nurmur  Bronchilis  Damaged heart valves  Systemic lupus erythematosus  Epilepsy  Heart murmur  Bronchilis  Neurological disorders  Epilepsy  Heart murmur  Bronchilis  Neurological disorders  Emphysema  Sleep disorder  High blood pressure  Emphysema  Sleep disorder  Rheumatic fever  Other heart defects  Cancer/Chemotherapy/Radiation  Kindey problems  Recurrent infections  Mitral valve prolapse  Cancer/Chemotherapy/Radiation  Kindey problems  Recurrent infections  Mitral valve prolapse  Cancer/Chemotherapy/Radiation  Ridney problems  Recurrent infections  Mitral valve prolapse  Cancer/Chemotherapy/Radiation  Cidney problems  Recurrent infections  Mitral valve prolapse  Cancer/Chemotherapy/Radiation  Cidney problems		-	illelit:					tohacco?	VES	NOO	
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Taking Birth control pills?  ALLERGIES, ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTION TO    Local anesthetics		$\sim$	NO		Nur	nher of v	weeks				
ALLERGIES, ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTION TO    Local anesthetics   Sulfa drugs   Iodine     Aspirin   Codeine or other narcotics   Hay fever/seasonal     Penicillin or other antibiotics   Metals   Animals     Sedatives or sleeping pills   Latex (rubber)   Food     Consentral HEART DISEASE (CHD) PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING;     Artificial (prosthetic) heart valve   Previous infective endocarditis   Repaired (completely) in the last 6 months     Damaged valves in transplanted heart   Repaired (Completely) in the last 6 months     Damaged valves in transplanted heart   Repaired (Completely) in the last 6 months     Cardiovascular disease (CHD)     OTHER DISEASES AND CONDITIONS - Please indicate if you have had or not had any of the following:     Cardiovascular disease   AlDS or HIV   Thyroid problems     Angina   Arthritis   Stroke   Stroke     Angina   Arthritis   Stroke   Glaucoma     Congestive heart failure   Rheumatoid arthritis   Hepatitis, jaundice or liver disease     Damaged heart valves   Systemic lupus erythematosus   Epillepsy     Hearth murmur   Bronchitis   Painting spells or seizures     Hearth murmur   Bronchitis   Neurological disorders     Low blood pressure   Emphysema   Sleep disorder     High blood pressure   Emphysema   Sleep disorder     High blood pressure   Sinus trouble   Mental health disorders     Other heart defects   Tuberculosis   Recurrent infections     Mitral valve prolapse   Cancer/Chemotherapy/Radiation   Night sweats     Rheumatic fever   Chronic pain   Osteoporosis     Rheumatic heart disease   Diabetes Type I or II   Persistent swollen glands in neck     Abnormal bleeding   Ger Reflux/persistent heartburn   Severe or rapid weight loss     Bood transfusion   Ger Reflux/persistent heartburn   Excessive urination     PREMEDICATION	<u> </u>						WCCKS	VES	NOO		
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Aspirin Ocodeine or other narcotics Animals Animals Animals Sedatives or sleeping pills Latex (rubber) Food  Other (please specify):  CONCENITAL HEART DISEASE (CHD) PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING;  Artificial (prosthetic) heart valve Previous infective endocarditis Repaired (completely) in the last 6 months Repaired CHD with residual defects  Congenital heart disease (CHD)  OTHER DISEASES AND CONDITIONS - Please indicate if you have had or not had any of the following:  Cardiovascular disease  Autoimmune disease  Autoimmune disease  Autoimmune disease  Autoimmune disease  Glaucoma  Congestive heart failure Repaired (completely) in the last 6 months  Stroke  Arteriosclerosis  Autoimmune disease  Glaucoma  Hearth attack  Asthma  Fainting spells or seizures  Hearth attack  Asthma  Fainting spells or seizures  Heart murmur  Bronchitis  Neurological disorders  Siepe disorders  Siepe disorders  Siepe disorders  Siepe disorders  Siepe disorders  Mental health disorders  Recurrent infections  Midral valve prolapse  Cancer/Chemotherapy/Radiation  Midral valve prolapse  Chest pain upon exertion  Night sweats  Rheumatic fever  Chest pain upon exertion  Night sweats  Rheumatic fever  Chonic pain  Diabetes Type I or II  Persistent swollen glands in neck  Severe or rapid weight loss  Sexually transmitted disease  Hemophilia  G.E. Reflux/persistent heartburn  Excessive urination  Doyou have any disease, condition, or problem not listed above that you think I should know about?	_ '	•						$\circ$	Iodine		
Penicillin or other antibiotics Sedatives or sleeping pills Latex (rubber) Food  Other (please specify):  CONGENITAL HEART DISEASE (CHD) PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING;  Artificial (prosthetic) heart valwe Pervious infective endocarditis Repaired (completely) in the last 6 months Pamaged valves in transplanted heart Congenital heart disease (CHD)  OTHER DISEASES AND CONDITIONS - Please indicate if you have had or not had any of the following:  Cardiovascular disease AIDS or HIV Thyroid problems  Anglina Arthritis Stroke Glaucoma  Arthritis Stroke Glaucoma  Arthritis Breath attack Asthma Fearth attack Asthma Fainting spells or seizures  Hearth attack Asthma Fainting Sinus trouble Meart disease Sinus trouble Metal heart disorders  High blood pressure Sinus trouble Metal hearth disorders  High blood pressure Sinus trouble Metal hearth disorders  Mitral valve prolapse Cancer/Chemotherapy/Radiation Recurrent infections  Rheumatic fever Cheronic pain Osteoporosis  Rheumatic fever Chronic pain Osteoporosis  Rheumatic fever Chronic pain Sexient swollen glands in neck Severe Perapid weight loss  Blood transfusion Gastrointestinal disease  Abnormal bleeding Gastrointestinal disease  Abnormal bleeding Gastrointestinal disease  Benybesian or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, please list their name and number.  Do you have any disease, condition, or problem not listed above that you think I should know about?	_		_		•	narcotics		_		nal	
Other (please specify):  CONGENITAL HEART DISEASE (CHD) PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING;											
Other (please specify):  CONCENITAL HEART DISEASE (CHD) PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING;  Artificial (prosthetic) heart valve Previous infective endocarditis Damaged valves in transplanted heart Congenital heart disease (CHD)  OTHER DISEASES AND CONDITIONS - Please indicate if you have had or not had any of the following:  Cardiovascular disease AlDS or HIV Thyroid problems Angina Arthritis Stroke Arteriosclerosis Autoimmune disease Autoimmune disease Congestive heart failure Rheumatoid arthritis Hepatitis, jaundice or liver disease Damaged heart valves Systemic lupus erythematosus Heart murmur Bronchitis Neurological disorders Haith blood pressure Heigh blood pressure Sinus trouble Other heart defects Mitral valve prolapse Cancer/Chemotherapy/Radiation Rheumatic fever Chronic pain Rheumatic fever Chronic pain Rheumatic fever Chronic pain Blood transfusion Blood transfusion Blood transfusion Gastrointestinal disease Hemophilia Repaired (completely) in the last 6 months Repaired (completely in the last 6 months Repaired (completels) Repaired (completels) Repaired (completel	_		_					_			
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Damaged valves in transplanted heart Congenital heart disease (CHD)  OTHER DISEASES AND CONDITIONS - Please indicate if you have had or not had any of the following:  Cardiovascular disease								cyanotic CHD			
Congenital heart disease (CHD)  OTHER DISEASES AND CONDITIONS - Please indicate if you have had or not had any of the following:  Cardiovascular disease AIDS or HIV Thyroid problems Argina Arthritis Stroke Arteriosclerosis Autoimmune disease Glaucoma Congestive heart failure Rheumatoid arthritis Hepatitis, jaundice or liver disease Epilepsy Hearth attack Asthma Fainting spells or seizures Heart murmur Bronchitis Neurological disorders Low blood pressure High blood pressure High blood pressure High blood pressure Content heart defects Mitral valve prolapse Cancer/Chemotherapy/Radiation Rheumatic fever Rheumatic fever Chest pain upon exertion Rheumatic fever Abnormal bleeding Abnormal bleeding Biood transfusion Blood transfusion Gastrointestinal disease Hemophilia  PREMEDICATION  PREMEDICATION  Thyroid problems Albor Thyroid problems Thyroid problems Thyroid problems Alor Thyroid problems Stroke Glaucoma Glaucoma Hepatitis, jaundice or liver disease Splaucoma Hepatitis, jaundice or liver disease Spellos versiver disease Spellos versiver disease Splep distroine disease Splep distroine disease Spellos versiver disease Splep distroine disease Spellos versiver disease Splep distroine disease Spellos versiver disease Splep distroine disease Splep distroin						0	Repaired (co	mpletely) in the	e last 6 months		
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Congestive heart failure Damaged heart valves Systemic lupus erythematosus Epilepsy Hearth attack Asthma Bronchitis Downblood pressure High blood pressure High blood pressure Cheer heart defects Date valves Pacemaker Chest pain upon exertion Rheumatic fever Rheumatic fever Rheumatic heart disease Abnormal bleeding Abnormal bleeding Blood transfusion or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, please list their name and number.  Do you have any disease, condition, or problem not listed above that you think I should know about?		_		dicasc	•		$\sim$				
Damaged heart valves							$\sim$		ndice or liver disc	200	
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<ul> <li>Pacemaker</li> <li>Rheumatic fever</li> <li>Chronic pain</li> <li>Rheumatic heart disease</li> <li>Diabetes Type I or II</li> <li>Abnormal bleeding</li> <li>Eating disorder</li> <li>Anemia</li> <li>Malnutrition</li> <li>Blood transfusion</li> <li>Gastrointestinal disease</li> <li>Hemophilia</li> <li>G.E Reflux/persistent heartburn</li> <li>Excessive urination</li> <li>PREMEDICATION</li> <li>Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, please list their name and number.</li> <li>Do you have any disease, condition, or problem not listed above that you think I should know about?</li> </ul>	Other heart defects	0	Tuberculosis				0	Recurrent infe	ections		
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Rheumatic heart disease Diabetes Type I or II Persistent swollen glands in neck Abnormal bleeding Eating disorder Severe Headaches/migraines Anemia Malnutrition Severe or rapid weight loss Blood transfusion Gastrointestinal disease Sexually transmitted disease Hemophilia G.E Reflux/persistent heartburn Excessive urination  PREMEDICATION  Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, please list their name and number.  Do you have any disease, condition, or problem not listed above that you think I should know about?	Pacemaker	0	Chest pain up	on exe	ertion		0	Night sweats			
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