Medical Information *For the following questions please mark (X) your responses to the following questions.* ***(Check DK if you Don't Know)***

	Yes	No	DK
Do you smoke?			
How many packs per day? _____			
Do you use tobacco (snuff, chew, bidis)?			

WOMEN ONLY Are you:	Yes	No	DK
Pregnant?			
Number of weeks: _____			
Taking birth control pills?			
Taking hormonal replacement?			
Nursing?			

	Yes	No	DK
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			

Date: _____ If yes, have you had any complications?

Allergies – Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK		Yes	No	DK
Amoxicillin_____				Latex (Rubber)_____			
Erythromycin_____				Local Anesthetic_____			
Penicillin_____				Metals_____			
Other antibiotics_____				Hay fever/Seasonal_____			
Codeine_____				Other_____			

Medical Conditions:
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. ***(Check DK if you Don't Know)***

	Yes	No	DK		Yes	No	DK		Yes	No	DK
Heart Murmur				Sinus Problems				Excessive Bleeding			
Mitral Valve Prolapse				Asthma				Tumors			
Artificial Heart Valve				Respiratory Problems				Cancer			
Congenital Heart Defect				Tuberculosis				Radiation Treatment			
Heart Disease				Thyroid Problems				Kidney Disease			
Heart Attack				Arthritis				Stomach Ulcers			
High Blood Pressure				Diabetes: Type I or II				Liver Disease			
Low Blood Pressure				Fainting				Hepatitis: Type _____			
Pacemaker				Epilepsy				HIV/AIDS			
Stroke				Neurological Disorders				Chemical Dependency			

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?			

Name of physician or dentist making recommendation: Phone:

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?			

Please explain:

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

FOR COMPLETION BY DENTIST

Comments: _____

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