

## MEDICAL HISTORY

Please answer the following questions to the best of your knowledge. Although prosthodontists primarily treat the mouth area, medical problems or medications could have a significant impact on your dental treatment. Your answers are confidential.

- Y     N    Are you in good health?
- Y     N    Are you under the care of physician? Date of last physical examination: \_\_\_\_\_
- Y     N    Have you had any illness, operation, or been hospitalized in the past 5 years? \_\_\_\_\_
- Y     N    Are you taking any medications?
- If yes, please list ALL medications you are taking:

Are you allergic to any of the following?

- Y     N    Aspirin
- Y     N    Codeine
- Y     N    Latex
- Y     N    Local Anesthetic
- Y     N    Penicillin
- Y     N    Sulfa drugs
- Y     N    Other Allergies

If yes, please list allergy/allergies:

Please indicate if presence of any of following medical conditions:

- Y     N    Abnormal (High/low) Blood pressure
- Y     N    AIDS / HIV
- Y     N    Anemia / Bleeding Problems
- Y     N    Artificial Heart Valves
- Y     N    Blood Disease
- Y     N    Congenital Heart Lesions
- Y     N    Heart Problems
- Y     N    Pacemaker
- Y     N    Arthritis/Rheumatism / Gout
- Y     N    Artificial Joints / Bones
- Y     N    Asthma
- Y     N    Cancer
- Y     N    Diabetes
- Y     N    Emphysema
- Y     N    Glaucoma
- Y     N    Radiation Treatment (Xray/Cobalt)



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Y     N     Shortness of breath (Breathing problems)  
Y     N     Sinus Trouble  
Y     N     Stoke/History of stroke.  
                 If yes, when was the last incident? \_\_\_\_\_ Are you on blood thinner? Y / N  
Y     N     Thyroid Problems  
Y     N     Tuberculosis  
Y     N     Ulcer  
Y     N     Epilepsy  
Y     N     Fainting / Dizziness  
Y     N     Headaches  
Y     N     Hepatitis  
Y     N     Herpes  
Y     N     Kidney/ Liver Disease  
Y     N     Psychiatric Care  
Y     N     Operations? If Y, Describe:  
Y     N     Hospitalized? If Y, Describe:

Do you have any other medical conditions that we should know about?

Y     N     Do you smoke or chew tobacco product(s)?  
Y     N     Do you drink alcohol? If yes, how frequent do you drink \_\_\_\_\_  
Y     N     Do you currently have or ever had a substance abuse problem?  
Y     N     Pregnant?  
Y     N     Nursing?

**Do you normally take antibiotics prior to dental appointments?**

Y     N

**Are you currently on any blood thinner medication?**

Y     N

**I have read and understand the above questions. I will not hold my prosthodontist/endodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Guardian/Authorized Representative: \_\_\_\_\_