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Phone: (801) 489-1000

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Physician's Name: _____ Phone: _____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

1. Do you consider yourself to be in good health? .....YES NO
2. Are you now or have you been under a physician's care within the past year? .....YES NO
   If Yes, specify condition being treated _____
3. Do you take any medications, including birth control pills? .....YES NO
   Please specify name and purpose of medications: _____
   _____
   _____
4. Do you have or have you ever had any heart or blood problems? .....YES NO
5. Have you ever been told that you have a heart murmur? .....YES NO
6. Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? .....YES NO
7. Do you have or have you ever had high blood pressure? .....YES NO
8. Do you bleed or bruise easily? .....YES NO
9. Have you ever been diagnosed as being HIV positive or having AIDS? .....YES NO
10. Have you ever had hepatitis or liver disease? .....YES NO
11. Have you ever had: rheumatic fever ☐; asthma ☐; any blood disorder ☐; diabetes ☐; rheumatism ☐; arthritis ☐; tuberculosis ☐; venereal disease ☐; heart attack ☐; kidney disease ☐; immune system disorders ☐; other disease ☐? If so, specify: _____
12. Have you ever had an unusual reaction or are you allergic to any of the following drugs: Penicillin ☐; Aspirin ☐; Acetominophen ☐; Ibuprofen ☐; Codeine ☐; Barbiturates ☐; Sulfa Drugs ☐; Other _____
13. Are you subject to fainting? .....YES NO
14. Have you ever had any severe reaction to dental treatment or local anesthetics? .....YES NO
15. Are you allergic to any local anesthetic? .....YES NO
16. Do you have any other allergies? .....YES NO
    If Yes, please describe: _____
17. Have you ever had a nervous breakdown or undergone psychiatric treatment? .....YES NO
18. Have you ever received counseling for use of alcohol and/or prescription drugs? .....YES NO
19. Women: Are you pregnant? .....YES NO
20. Are you now in pain? .....YES NO
21. How long ago did you last see a dentist? _____
22. Who was your previous dentist? _____
23. Do you think that your teeth are affecting your general health in any way? .....YES NO
24. Do you have or have you ever had bleeding or sensitive gums? .....YES NO
25. Have you ever taken Phen-Fen or similar appetite suppressants? .....YES NO
    If Yes, have you seen your physician or cardiologist for a cardiac evaluation? .....YES NO
26. Have you ever used or are you now using tobacco or alcohol? .....YES NO
27. Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? .....YES NO

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature _____ Date _____
(Patient, legal guardian or authorized agent of patient)