

**GENERAL MEDICAL HISTORY**

Name of physician \_\_\_\_\_

Address \_\_\_\_\_ tel. # \_\_\_\_\_

Date of last physical exam \_\_\_\_\_

Are you being treated for any current condition? \_\_\_\_\_

If so, What? \_\_\_\_\_

**HAVE YOU BEEN DIAGNOSED WITH**

HEPATITIS? \_\_\_\_\_

Which type? \_\_\_\_\_

DIABETES? \_\_\_\_\_ HOW MANY YEARS SINCE DIAGNOSED? \_\_\_\_\_

DO YOU TAKE ANY MEDICATIONS FOR THIS? \_\_\_\_\_

IF SO, WHAT? \_\_\_\_\_

HOW OFTEN DO YOU CHECK YOUR LEVELS? \_\_\_\_\_

HEART MURMUR? \_\_\_\_\_

RHEUMATIC FEVER? \_\_\_\_\_

MITRAL VALVE PROLAPSE? \_\_\_\_\_

HEART CONDITION OR HISTORY OF HEART TREATMENT? \_\_\_\_\_

TUMOR OR CANCER? \_\_\_\_\_

HIV OR AIDS? \_\_\_\_\_

TUBERCULOSIS? \_\_\_\_\_

ARTIFICIAL JOINT OR LIMB? \_\_\_\_\_

ANEMIA? \_\_\_\_\_

ABNORMAL BLEEDING CONDITION? \_\_\_\_\_

HAS YOUR PHYSICIAN TOLD YOU THAT YOU NEED TO TAKE ANTIBIOTICS PRIOR TO DENTAL TREATMENT? Y\_\_ N\_\_

ALLERGY TO MEDICATIONS? \_\_\_\_\_ PLEASE LIST AND DESCRIBE REACTION

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ALLERGY TO LATEX? \_\_\_\_\_ OTHER ALLERGIES? \_\_\_\_\_

LIST ALL CURRENT MEDICATIONS AND REASON PRESCRIBED (INCLUDING NON-PRESCRIPTION DRUGS AND VITAMINS)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(OVER)

ARE YOU TAKING BIRTH CONTROL PILLS? \_\_\_\_\_

ANY HOSPITALIZATIONS OR SURGERY IN THE PAST 10 YEARS. PLEASE EXPLAIN

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DO YOU SMOKE OR USE TOBACCO PRODUCTS? \_\_\_\_\_

IF SO, HOW MUCH? \_\_\_\_\_

HOW MANY YEARS? \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_