PT LABEL HERE

Medical History Date:_____

Do you have or have you had?	
YES NO	
Alcohol /Drug Abuse	If yes, did you quit? How long ago?
Artificial Heart Valves	If yes when? _____
Artificial Joints/Implants	If yes, when? Pre-med to surgery?
Asthma/Emphysema	If yes, do you have an inhaler? Last time used?
Cancer/Multiple Myeloma	If yes, Type of Cancer? Type of Treatment? Name of Oncologist : _____ Name of Radiologist : _____
Chemical Dependency	If yes, what kind? _____
Chemotherapy/Radiation	If yes when, what kind, and what doctor?
Cortisone (Steroids) COVID/Antibody +	If yes, Oral or Iv? _____ If yes when,_____
Diabetes/Hypoglycemia	If yes, Type 1 or 2? Are you currently taking insulin?
Epilepsy/Seizures	If yes, Last Episode? _____
Heart Murmur	If yes, Current or as Child? _____
Heart Problems/Stroke	If yes which one and when? _____ What doctor did you see? _____
Hepatitis	If yes, what type?
Kidney Disease	What is your dialysis schedule?

Mitral Valve Prolapse	If yes, Pre-med? What doctor?
Pacemaker/Heart Surgery	If yes, when? _____

Psychiatric/Behavior Problems	If yes, Specifically? _____

Rheumatic Fever	Shortness of Breath
Scarlet Fever	Thyroid Disease
Tobacco Habit	HIV/AIDS
Liver Disease	Glaucoma
High/Low Blood Pressure	Bleeding Disorder or take High Dose Aspirin

Sickle Cell Disease/Trait	If yes, Last Hospitalization?
Ulcers/GI Problems?	If yes what?

Have you ever taken Bisphosphonates/Bone Drugs (ex:Evista/Fosamax/Prolia/Reclase/ Zometa) **YES NO DON'T KNOW**	**Do you require Pre-Op Antibiotics prior to any Dental Procedures due to medical conditions such as Heart Valves, Rheumatic Fever and/or artificial joints?** **YES NO DON'T KNOW**	**Are you currently in Pain Management Care? YES NO** **Dr.**_____
Primary Care **Dr.**_____ **Hospital:**_____ **Preferred Pharmacy** **Name:**_____ **Telephone:**_____	**Weight:**_____ **Height:**_____ **FEMALES ONLY:** **Are you pregnant? Y N** **Nursing:? Y N** **Last Menstrual Period:**_____ **or N/A**	**Are you allergic to the following?** **YES NO** **Latex** **Penicillin** **Sulfa** **Tetracycline** **Aspirin** **Codeine** **NSAIDS (Motrin,Aleve,Advil)** **Other:**_____

Other (Including Special Needs/Disabilities)	If yes what?

Surgery History:

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