

**Medical Information: side 1**

**Patient Info**

Patient Name \_\_\_\_\_  
Last First MI (Preferred Name)

SS #: \_\_\_\_\_

**Medical Info**

- Yes No 1) Are you in good health?  
 Yes No 2) Has there been any change in your general health within the past year?  
 Yes No 3) Are you now under the care of a physician?  
 If so, what is the condition being treated? \_\_\_\_\_  
 Physician's Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Yes No 4) Date of last physical examination \_\_\_\_\_  
 Yes No 5) Are you taking medicines, including non-prescription medicine?  
 If yes, what medicine? \_\_\_\_\_

**Women Only**

- Yes No 6) Are you pregnant?  
 Yes No 7) Nursing?  
 Yes No 8) Taking birth control pills?

**Conditions**

Do you have any of the following diseases or problems?

- |   |   |
|---|---|
| Yes No 9) Abnormal bleeding   | Yes No 38) G.F. reflux  |
| Yes No 10) AIDS or HIV  | Yes No 39) Glaucoma   |
| Yes No 11) Anemia   | Yes No 40) Hemophilia   |
| Yes No 12) Arthritis  | Yes No 41) Hepatitis, jaundice or liver disease   |
| Yes No 13) Rheumatoid arthritis   | Yes No 42) Recurrent infections Specify _____   |
| Yes No 14) Asthma   | Yes No 43) Kidney problems  |
| Yes No 15) Blood transfusion If yes, date _____   | Yes No 44) Low blood pressure   |
| Yes No 16) Cancer/chemotherapy/radiation treatment  | Yes No 45) Mental health disorders Specify _____  |
| Yes No 17) Cardiovascular disease   | Yes No 46) Migraines  |
| Yes No 18) Angina   | Yes No 47) Night sweats   |
| Yes No 19) Arteriosclerosis   | Yes No 48) Neurological disorders Specify: _____  |
| Yes No 20) Artificial heart valves  | Yes No 49) Osteoporosis   |
| Yes No 21) Coronary insufficiency   | Yes No 50) Persistent swollen glands in neck  |
| Yes No 22) Coronary occlusion   | Yes No 51) Respiratory problems   |
| Yes No 23) Damaged heart valves   | If yes, specify: <input type="checkbox"/> Emphysema <input type="checkbox"/> Bronchitis     |
| Yes No 24) Heart attack   | Yes No 52) Severe headaches   |
| Yes No 25) High blood pressure  | Yes No 53) Severe or rapid weight loss  |
| Yes No 26) Inborn heart defects   | Yes No 54) Sexually transmitted disease   |
| Yes No 27) Mitral valve prolapse  | Yes No 55) Sinus trouble  |
| Yes No 28) Pacemaker  | Yes No 56) Sleep disorder   |
| Yes No 29) Chest pain upon exertion   | Yes No 57) Sores or ulcers in the mouth   |
| Yes No 30) Chronic pain   | Yes No 58) Stroke   |
| Yes No 31) Persistent diarrhea  | Yes No 59) Systemic lupus erythematosus   |
| Yes No 32) Disease, drug or radiation-infection induced immunosuppression                             | Yes No 60) Thyroid problems   |
| Yes No 33) Diabetes, if yes, specify <input type="checkbox"/> Type I <input type="checkbox"/> Type II | Yes No 61) Tuberculosis   |
| Yes No 34) Dry mouth  | Yes No 62) Ulcers   |
| Yes No 35) Eating disorder Specify _____  | Yes No 63) Excessive urination  |
| Yes No 36) Epilepsy   | Yes No 64) Any other diseases, condition or problem not listed above? Please explain: _____ |
| Yes No 37) Fainting spells or seizures  |   |

**Medical Information: side 2**

**Conditions**

- 65) Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?  
If so, what antibiotic and dose? \_\_\_\_\_  
Name of physician or dentist: \_\_\_\_\_ Phone: \_\_\_\_\_
- 66) Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?  
If so, when was this operation done? \_\_\_\_\_
- 67) If yes, Have you had any complications or difficulties with your prosthetic joint? \_\_\_\_\_  
\_\_\_\_\_

**Allergies**

Are you allergic or have you had a reaction to:

- |     |    |     |   |     |    |     |                       |
|-----|----|-----|---|-----|----|-----|-----------------------|
| Yes | No | 68) | Local anesthetics                         | Yes | No | 74) | Latex                 |
| Yes | No | 69) | Aspirin                                   | Yes | No | 75) | Iodine                |
| Yes | No | 70) | Penicillin or other antibiotics           | Yes | No | 76) | Hay fever/seasonal    |
| Yes | No | 71) | Barbiturates, sedatives or sleeping pills | Yes | No | 77) | Animals               |
| Yes | No | 72) | Sulfa drugs                               | Yes | No | 78) | Food (specify) _____  |
| Yes | No | 73) | Codeine or other narcotics                | Yes | No | 79) | Other (specify) _____ |

If yes responses, specify type or reaction \_\_\_\_\_

**Signatures**

I understand and authorize Drs. Masci and Hale and associates to perform and/or administer any and all forms of treatment, medication and anesthesia that may be necessary. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I certify that I have read and understand the above.

Print Name: \_\_\_\_\_

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