PERFORMANCE DENTAL CENTER

Patients Name : _____

Patients Medical History

Name of Family physician: _____ **Phone Number**: _____

How is your overall general Health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last Medical Exam: _____ **Nature of Exam**: _____

Please check all that apply:

- ☐ Abnormal Bp High___Low___
- ☐ Aids
- ☐ Angina/Chest Pain
- ☐ Artificial Hip/Joint/Limb
- ☐ Asthma
- ☐ Bacterial Endocarditis
- ☐ Breathing Problems
- ☐ Bleeding Disorder
- ☐ Cancer/Tumors
- ☐ Chemo-Therapy
- ☐ Congenital Heart Problem
- ☐ Diabetes TYPE ____
- ☐ Epilepsy/Seizures
- ☐ Frequent Headaches
- ☐ Heart Valve Replacement
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Heart Surgery
- ☐ Hearing Aid/Loss
- ☐ Hepatitis TYPE ___
- ☐ Herpes Virus/Cold Sores
- ☐ HIV Positive
- ☐ Kidney Trouble
- ☐ Liver Trouble
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Sinus Trouble/ Sinusitis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcers/Colitis
- ☐ Other _____
- ☐ **NONE OF THE ABOVE**

Have you ever had a serious illness or operation? ☐ YES ☐ NO **Please Explain**: _____

Have you been hospitalized during the past five years? ☐ YES ☐ NO **Why?** _____

Are you limited in activity because of a physical or medical condition? ☐ YES ☐ NO

Are you currently taking any medications, pills, drugs or supplements? ☐ YES ☐ NO
Please list: _____
_____

Have you ever taken medication for osteoporosis such as Fosamax, Boniva, Actonel. If so please list ☐ YES ☐ NO
_____

Have you ever had any serious problems associated with previous dental treatment or dental anesthetic? ☐ YES ☐ NO
Please explain: _____

Do you smoke/chew tobacco products? ☐ YES ☐ NO **How Often?** _____ **Length of use?** _____

Women: Do you take birth control? ☐ YES ☐ NO
Are you Pregnant (if maybe check yes)? ☐ YES ☐ NO **If yes please give delivery date:** _____
Are you Nursing? ☐ YES ☐ NO
Is there any other disease, condition, or problem not listed above? ☐ YES ☐ NO
Please explain: _____

Are you allergic to (please check)

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Metals
- ☐ Pain Medications
- ☐ Penicillin
- ☐ Sulfa

Please list any other allergies: _____

I, the undersigned (patient or legal guardian), certify that the information given on this form is true and correct.

Patient/Legal Guardian Signature: _____ **Date:** _____