Barnett Family Dentistry
Medical History

Patient Name: ____________________________ Birth Date: __________ Male / Female

Physician Name: _________________ Date of Last Visit: __________

Please circle the appropriate answer to all questions. Please ask about any questions you do not understand.

1.	Have you ever had heart trouble? Describe…………………………………………	yes / no
2.	Do you have a pacemaker?..	yes / no
3.	Have you ever had rheumatic fever?...	yes / no
4.	Have you ever had joint replacement surgery?……………………………….............	yes / no
5.	Have you ever been advised to take antibiotics before dental treatment?.....................	yes / no
6.	Have you ever had a reaction (allergy) to any drugs or medicines?............................	yes / no
7.	Do have sensitivity to latex?..	yes / no
8.	Do you have sensitivity to any metals?...	yes / no
9.	Have you ever had excessive bleeding after extractions or cuts?.................................	yes / no
10.	Have you ever had hepatitis, except as an infant?..	yes / no
11.	Have you ever had a thyroid condition?..	yes / no
12.	Have you ever had asthma, hay fever, or bronchitis?...	yes / no
13.	Have you ever had high blood pressure? Low blood pressure?...................................	yes / no
14.	Do you have a cold or sore throat?...	yes / no
15.	Have you ever had stomach ulcers?..	yes / no
16.	Do you have diabetes or hypoglycemia?...	yes / no
17.	Do you have a history of epilepsy or seizure disorder?..	yes / no
18.	Have you ever been diagnosed with cancer?..	yes / no
19.	Have you ever had radiation therapy?..	yes / no
20.	Have you ever had tuberculosis?..	yes / no
21.	Have you been treated by a physician or been hospitalized in the last year?................	yes / no
22.	Have you ever had a serious illness or condition?..	yes / no
23.	Have you tested HIV positive? Do you have AIDS?..	yes / no
24.	Have you ever had a venereal disease?..	yes / no
25.	Do you have a history of drug addiction or chemical dependency?..............................	yes / no
26.	Do you use any tobacco products?..	yes / no
WOMEN		
27.	Are you pregnant?...	yes / no
28.	Are you nursing?...	yes / no
29.	Are you taking birth control pills?..	yes / no

MEDICATIONS CURRENTLY BEING TAKEN

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ALLERGIES TO MEDICATIONS (circle)

Aspirin	**Local Anesthetic**	**Sulfa**
Codeine	**Iodine**	**Penicillin**
Latex	**Sleeping Pills**	

Other:__________________________

IN THE EVENT OF AN EMERGENCY, PLEASE NOTIFY____

HOME#:_________________________ **CELL#:**_________________________ **WORK#:**_________________________

PATIENT/GUARDIAN SIGNATURE:____________________ **DATE:**_________

REVIEWED WITH PATIENT BY:_______________________ **DATE:**_________