Wibicki Family Dental

MEDICAL HISTORY

Patient Name_____Today's Date_____

It is very important to tell all dental personnel about the general state of your health. It is also critical that you inform us of any change in your health status, including any medications you take, pregnancy or current conditions. Although it may not appear there is a link between certain medical conditions and dental treatment, this is often not the case. Please answer truthfully; all information disclosed is CONFIDENTIAL.

How would you describe your general health?_____

Have you been treated by a physician in the past 2 years? Yes No

If yes, explain:_____

Name of Physician_____Phone_____

(Circle appropriate response)

Do you or have you had the following:

Any serious infectious disease?	**Yes/No**	**Heart or cardiovascular disease?**	**Yes/No**
AIDs or tested HIV positive?	**Yes/No**	**Have you had a heart attack?**	**Yes/No**
Hepatitis?	**Yes/No**	**High blood pressure?**	**Yes/No**
Tuberculosis?	**Yes/No**	**CVA, stroke?**	**Yes/No**
MRSA resistant bacteria?	**Yes/No**	**Mitral Valve prolapsed?**	**Yes/No**
Venereal Disease?	**Yes/No**	**Valve Replacement?**	**Yes/No**
Glaucoma?	**Yes/No**	**Joint Replacement?**	**Yes/No**
Diabetes?	**Yes/No**	**Rheumatic Fever?**	**Yes/No**
Arthritis?	**Yes/No**	**Bleeding Disorders?**	**Yes/No**
Cancer?	**Yes/No**	**Asthma?**	**Yes/No**
Radiation therapy?	**Yes/No**	**COPD, emphysema?**	**Yes/No**

Date	Updated Information	Dr .Init.

Please complete the remainder of the form on reverse side!

Date of Birth ____/____/_____ Name_____ [ ]

Have you ever been told by a physician that you should be pre-medicated with an antibiotic for dental treatment? Yes/No

If yes, explain:_____

Please list or attach list of any medications or drugs that you are taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Circle any of the following you are allergic to: (list any items not included)

Penicillin	**latex**	**anesthetic**	**metals**	**_____**
Amoxicillin	**sulfa**	**epinephrine**	**aspirin**	**_____**
Ibuprofen	**Tylenol**	**chemicals**	**codeine**	**_____**

Women: Are you pregnant? Yes/No Are you taking birth control? Yes/No

Please include here, any additional information about your medical condition you believe would aid us in your treatment:

To the best of my knowledge, all of the preceding answers are true and correct. If in the future there is a change in my health or medications, I will inform the doctor or his staff prior to the performing of any treatment. All of the information given is considered confidential and protected by the HIPPA rules and regulations.

Please sign here. If patient is a minor, the undersigned is a parent or guardian and gives authorization for treatment Signature_____Date_____