MEDICAL HISTORY FOR DENTAL TREATMENT

Patient's Name: _____

Please answer all questions by circling Yes or No, and provide details where requested.
Dr. Mosser will be pleased to discuss any questions you find to be unclear. Thank you.

1. Are you in good health? ..... YES NO
2. Are you now under a physician's care? ..... YES NO
   If so, give reason for treatment _____
   Name of physician _____
3. Are you now, or have you been taking drugs or medication such as pills, capsules, injections, or liquids? ..... YES NO
   If so, what? _____
4. Are you allergic or sensitive to any drugs, medicines or injections (e.g., penicillin, Novocaine, aspirin, codeine, etc.)? ..... YES NO
   If yes, which substance(s)? _____
5. Are you sensitive or allergic to latex? ..... YES NO
6. Have you ever had a prolonged illness or hospitalization? ..... YES NO
   Reason: _____
7. Prophylactic antibiotics may be indicated prior to dental treatment in some cases. Have you ever had:
   a) Prosthetic joint or heart valve replacement? ..... YES NO
   b) Previous infective endocarditits? ..... YES NO
   c) Heart transplant, or any other heart surgery (excluding bypass surgery)? ..... YES NO
8. Do you take Fosamax, Actonel, or other bisphosphonate (oral or intravenous)? ..... YES NO
9. Have you ever had or been treated for:
   a) Heart condition or attack? ..... YES NO
   b) High or low blood pressure? ..... YES NO
   c) Anemia or blood disorder? ..... YES NO
   d) Diabetes? ..... YES NO
   e) Stomach, intestinal, or digestive disorder? ..... YES NO
   f) Kidney disease? ..... YES NO
   g) Liver disease (yellow jaundice, hepatitis)? ..... YES NO
   h) Thyroid Disorder? ..... YES NO
   i) Tuberculosis? ..... YES NO
   j) Asthma, hay fever, or sinus condition? ..... YES NO
   k) Seizures, convulsions, or fainting spells? ..... YES NO
   l) Syphilis or other venereal disease? ..... YES NO
   m) Malignancy or cancer? ..... YES NO
10. Have you ever had radiation therapy? ..... YES NO
11. Have you ever had prolonged bleeding from injury, tooth extraction or other surgery? ..... YES NO
12. Are you presently taking a blood thinner such as Coumadin, Plavix, or aspirin on a daily basis? ..... YES NO
13. Are you now or have you ever taken cortisone, steroids? ..... YES NO
14. Are there any diseases that tend to occur in more than one member of your family? ..... YES NO
15. Do you have a cardiac pacemaker? ..... YES NO
16. Women: Are you presently, or think you may be, pregnant? ..... YES NO
    If so, how many months? _____
17. Do you have any disease, condition, or problem not listed above? ..... YES NO

Patient or Guardian's Signature	Date	Dr. Mosser's Initials
(Original) _____	_____	_____
(Rechecked) _____	_____	_____
(Rechecked) _____	_____	_____
(Rechecked) _____	_____	_____
(Rechecked) _____	_____	_____
(Rechecked) _____	_____	_____