# Great Lakes Dental Center

## Medical History

**It is important to tell all dental personnel involved in your treatment about the general state of your health.**
**This information is confidential.**

Patients Name: ______________________________ Date of Birth ____/____/______

Patients Home/Cell Phone Number: (__________)______________________________

1. Name and address of physician ______________________________
2. When was your last physical examination? ______________________________
3. Are you now under the care of a physician? Yes ☐ No ☐ If yes, for what reason? ______________________________
   ______________________________
4. Name of Pharmacy ______________________________ Town ______________________________
5. Have you been told you should be taking an antibiotic (premedication) prior to dental visits? Yes ☐ No ☐
6. Are you taking a blood thinner(Coumadin)?........................................ Yes ☐ No ☐
7. Are you presently taking any medications/drugs/pills?........................................ Yes ☐ No ☐
   Please List: or provide a list to be copied ______________________________
   ______________________________
   ______________________________
8. Are you presently taking a medication for soft bone (osteoporosis) (Fosamax)? Yes ☐ No ☐
9. (Women) Are you pregnant? Yes ☐ No ☐ If yes, Due Date? ______________________________
10. Are you allergic to: Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Latex ☐ None ☐ Other ☐ ______________
11. Do you have, or have you ever had:

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| Heart Trouble........................ | Yes ☐ | No ☐ | Excessive or Prolonged Bleeding......... | Yes ☐ | No ☐ |
| Heart Murmur........................ | Yes ☐ | No ☐ | Fainting Spells........................ | Yes ☐ | No ☐ |
| Heart Surgery........................ | Yes ☐ | No ☐ | Jaundice/Liver........................ | Yes ☐ | No ☐ |
| Heart Pacemaker...................... | Yes ☐ | No ☐ | Hepatitis - Type:...................... | Yes ☐ | No ☐ |
| Rheumatic Fever...................... | Yes ☐ | No ☐ | Asthma or Hay Fever................. | Yes ☐ | No ☐ |
| High or Low Blood Pressure........... | Yes ☐ | No ☐ | Sinus Trouble........................ | Yes ☐ | No ☐ |
| Ulcers.............................. | Yes ☐ | No ☐ | Cancer.............................. | Yes ☐ | No ☐ |
| Tuberculosis, Lung Disease/COPD...... | Yes ☐ | No ☐ | Chemotherapy/Radiation.............. | Yes ☐ | No ☐ |
| Diabetes............................ | Yes ☐ | No ☐ | Stroke.............................. | Yes ☐ | No ☐ |
| Epilepsy or Seizure Disorders.......... | Yes ☐ | No ☐ | Glaucoma........................... | Yes ☐ | No ☐ |
| Anemia.............................. | Yes ☐ | No ☐ | Psychiatric Care...................... | Yes ☐ | No ☐ |
| Thyroid Problem...................... | Yes ☐ | No ☐ | Venereal Disease..................... | Yes ☐ | No ☐ |
| Chemical Dependency................. | Yes ☐ | No ☐ | HIV Positive/AIDS/ARC.............. | Yes ☐ | No ☐ |
| Smoke/Chew or use any form Tobacco... | Yes ☐ | No ☐ | Prosthetic Implant/Joint Replacement.... | Yes ☐ | No ☐ |
| Arthritis............................ | Yes ☐ | No ☐ | Chloesterol Treatment................. | Yes ☐ | No ☐ |

12. Have you had any other serious illnesses, hospitalization or accident? Yes ☐ No ☐
    If yes, please explain ______________________________
    ______________________________
    ______________________________

Patient's/Guardian's Signature ______________________________ Date ____/____/____