



**SUMMIT DENTAL CARE**

**Medical History**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- Yes  No Have there been any changes to your health in the past year?  
 Yes  No Are you seeing a physician for any conditions?  
 Physician's Name & Phone #: \_\_\_\_\_  
 Yes  No Have you been hospitalized or had a major operation in the past five years?

<b>Are you allergic to any of the following?</b>	<b>Women: are you</b>
<input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Acrylic	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Metal <input type="checkbox"/> Latex <input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Nursing
<input type="checkbox"/> Other (please list): _____	<input type="checkbox"/> Taking birth control (antibiotics may affect it)

**Do you have, or have you had, any of the following (\* indicates antibiotic premedication may be needed):**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heart Attack/Failure             | <input type="checkbox"/> AIDS/HIV Positive    | <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Heart Disease/Angina             | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Emphysema               |
| <input type="checkbox"/> Infectious Endocarditis*         | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Congenital Heart Defect*         | <input type="checkbox"/> Herpes               | <input type="checkbox"/> Sinus Trouble/Hay Fever |
| <input type="checkbox"/> Artificial Heart Valve*          | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Kidney Disease          |
| <input type="checkbox"/> Heart Transplant*                | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Arthritis/Gout          |
| <input type="checkbox"/> Artificial Joint*                | <input type="checkbox"/> Chemotherapy         | <input type="checkbox"/> Epilepsy/Seizures       |
| <input type="checkbox"/> Anemia                           | <input type="checkbox"/> Leukemia             | <input type="checkbox"/> Glaucoma                |
| <input type="checkbox"/> Blood Disorders                  | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Recent Weight Loss      |
| <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Tumors/Growths       | <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> Low Blood Pressure               | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Canker Sores            |
| <input type="checkbox"/> Stroke                           | <input type="checkbox"/> Lung Disease         | <input type="checkbox"/> Chemical Dependency     |
| <input type="checkbox"/> Pacemaker/Internal Defibrillator | <input type="checkbox"/> Breathing Problems   | <input type="checkbox"/> Tobacco Use             |

**Medications**

- Antibiotics \_\_\_\_\_  
 Anticoagulants (blood thinners) \_\_\_\_\_  
 High Blood Pressure Medication \_\_\_\_\_  
 Antidepressants \_\_\_\_\_  
 Cortisone (steroids) \_\_\_\_\_  
 Any other medications \_\_\_\_\_

**Name of Person to Contact in Case of Emergency**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_