

Patient
Name: _____

T. Michael McHenry, DDS, PA

214 East Eau Gallie Blvd, Indian Harbour Beach, FL 32937

Office Use
ASA _____



MEDICAL HISTORY

Please list **ALL prescription medications, herbal products and over-the-counter products you are taking.** If you take any "street drugs", please list them. *Any* drug can interact with the medications we administer. Your medical information is private and your health is important.

Do you have or have you had any of the following? (Please circle Yes or No)

Congenital Heart Defect	Yes	No	Rheumatic Fever	Yes	No
Mitral Valve Prolapse	Yes	No	Heart Murmur	Yes	No
Heart Surgery	Yes	No	Joint Replacement	Yes	No
If yes, how long ago? _____			If yes, what type? _____		

Antibiotic Pre-medication

A "YES" answer to any of the above questions may require antibiotic pre-medication or a release from your physician prior to any dental treatment.

If I require antibiotic pre-medication, I understand and agree that it is my responsibility to take the prescribed antibiotics as directed before ANY dental procedure is performed. If I need another prescription for pre-medication, I will ask. I understand that failure to take the antibiotic premedication can result in serious medical complications.

Initial: _____

Asthma or Emphysema	Yes	No	Diabetes	Yes	No
Heart Attack	Yes	No	Pacemaker	Yes	No
Abnormal Bleeding	Yes	No	Hemophilia	Yes	No
Cancer / Chemotherapy	Yes	No	Radiation Therapy	Yes	No
Liver Disease / Hepatitis	Yes	No	Kidney Disease	Yes	No
Epilepsy or Seizures	Yes	No	Stroke	Yes	No
Blood Transfusions	Yes	No	HIV+ or AIDS	Yes	No
High or Low Blood Pressure	Yes	No	Anemia	Yes	No
Alcohol Use (2+ drinks daily)	Yes	No	Tuberculosis (TB)	Yes	No
Tobacco Use	Yes	No	Thyroid Problems	Yes	No
Sinus Problems	Yes	No	Herpes / Fever Blisters	Yes	No

Are you ALLERGIC to any of the following?

Penicillin	Yes	No	Tetracycline	Yes	No	Erythromycin	Yes	No
Sulfa or Sulfides	Yes	No	Aspirin	Yes	No	Codeine	Yes	No
Dental Anesthetics	Yes	No	Jewelry or Metals	Yes	No	Latex	Yes	No

List any other allergies you may have. _____

Are you currently undergoing medical treatment? Yes No What is your current physical health? _____

Please explain any "YES" answer. Also, list any other medical conditions or limitations you have that are not listed above.

I certify that the information I have given on this medical history form is correct and complete to the best of my knowledge. I also understand that complete, correct and up-to-date information is important for my well-being and safety. I understand and agree that it is my responsibility to inform this office of any changes in my medical status before any treatment is rendered.

Patient Signature _____ Date ____/____/____