Medical History Report

Patient's Name: ____Tel#: _________________ Date: _____________

Patient's Address:____

Reason for Request: ____

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PLEASE COMPLETE ALL THE MARKED QUESTIONS

___ Complete A through E

A. What are your most recent medical findings and /or diagnosis?

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____

B. What medication is the patient currently taking? (Please indicate dosage.)

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C. Should the dosage be altered for surgical procedures? If yes, please specify change.

____

D. Do you recommend any special considerations for this patient during dental treatment? Our initial examination indicates that the patient may require:

- ___ General Dentistry (non-surgical)
- ___ Extractions
- ___ Root Canal therapy
- ___ Periodontal Surgery

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E. Is there any reason why this patient cannot receive dental treatment at this time?

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____ Is antibiotic prophylaxis indicated for this patient? Yes___ No ___
(AHA-ADA recommended regimens are followed.)

____ What are the results of the most recent Hepatitis B surface antigen test?

____

____ What are the results of the most recent serology or culture?

____

____ Other: ____

Physician's Signature: ___________________________________ Date: ______________________________

Physician's Name (Please Print): ____

Address:____

Tel #: ____