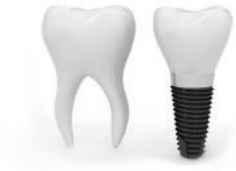

Erich C. Schmidt
D.M.D

MEDICAL HEALTH HISTORY

PATIENT NAME: _____

1. Do you have a joint replacement or heart condition which requires antibiotic pre-medication 1 hour prior to EVERY dental appointment? □ YES □ NO

DOCTOR(S) NAME _____ PHONE(S) _____

2. Are you taking any medication(s) including non-prescription medicine? YES □ NO □

If yes, what medication(s) are you taking? _____

3. Do you use alcohol, tobacco, or other drugs? YES □ NO □

4. Are you on any blood thinners? (eg:) Plavix Coumadin Warfarin Aspirin YES □ NO □

5. Are you allergic to or have you had any reactions to the following?

	YES	NO		YES	NO
Penicillin	□	□	**Latex**	□	□
Local Anesthetics	□	□	**Sedatives**	□	□
Sulfa Drugs	□	□	**Iodine**	□	□
Barbiturates	□	□	**Aspirin**	□	□

Other Allergies _____

6. WOMEN ONLY

	YES	NO
a) Are you pregnant or think you might be pregnant?	□	□
b) Are you nursing?	□	□
c) Are you taking birth control pills?	□	□
d) Are you taking Bisphosphonates? (eg: Fosamax)	□	□

7. Do you have or *have you had* any of the following?

	YES	NO		YES	NO		YES	NO
Heart Attack	□	□	Asthma	□	□	Tuberculosis	□	□
Heart Disease	□	□	Emphysema	□	□	Sexually Transmitted Disease	□	□
Heart Murmur	□	□	Respiratory Problems	□	□	Liver Disease	□	□
Cardiac Pacemaker	□	□	Cancer	□	□	High Blood Pressure	□	□
Glaucoma	□	□	Leukemia	□	□	Low Blood Pressure	□	□
Joint Replacement or Implant	□	□	Radiation Treatment	□	□	Anemia	□	□
IBS	□	□	Stroke	□	□	Diabetes	□	□
Stomach Troubles/Ulcer	□	□	Fainting/Seizures	□	□	Thyroid Problem	□	□
Rheumatic Fever	□	□	Epilepsy/Convulsions	□	□	Kidney Disease	□	□
Angina	□	□	Hepatitis	□	□	Arthritis	□	□
Chest Pains	□	□	Jaundice	□	□	Hay Fever/Allergies	□	□
Arrhythmia	□	□	AIDS/HIV Infections	□	□	Frequently Tired	□	□

COMMENTS _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____

PATIENT, PARENT, OR GUARDIAN DATE