Jerry M. Rosenberg, DMD
Complete Dental Care

MEDICAL HISTORY

Physician Name:____
Address:____
Telephone Number______________________________________

Have you ever had, been treated for, or told that you had:
(please check all that apply)

☐Rheumatic Fever
☐Heart Murmur
☐At-birth Heart Defect/Surgery
☐Hip/Knee Replacement
☐ Mitral Valve Prolapse
☐Infective Endocarditis
☐Atrial Fibrillation
☐Pacemaker
☐Heart Valve Replacement
☐Heart Attack
☐Other Heart Problems ________________________________
☐Heart Surgery - Date:________________________________
☐Transplant Surgery – Date______________________________
☐Other Surgeries - ___________________________________

☐Diabetes
☐Stroke
☐Excessive Bleeding
☐Blood Disorder
☐Hepatitis
☐Asthma/Emphysema
☐Arthritis
☐Sinus Problems
☐Malignancies
☐Angina
☐Blood Transfusion
☐High Blood Pressure
☐Circulatory Problems
☐Diet Pills/Phen-Fen
☐Bronchitis
☐HIV/AIDS
☐Radiation Therapy
☐Chemo Therapy
☐Tuberculosis
☐Nervous Problems
☐Do you Smoke?
☐Chew Tobacco?

***Have you ever needed to be pre-medicated with antibiotics for dental work?**______

Please check off any medications you are presently taking:

☐Blood Pressure
☐Blood Thinner
☐Birth Control Pills

Please list any other medications you are taking:
____
____
____

Allergies to any medicines? (e.g. Penicillin, Codeine, Aspirin, Novocaine, etc.)
(explain)____
____

If Female: Are you pregnant or contemplating pregnancy?______________
Nursing?______________

Any other conditions?______________________________________

Signature:____________________________ **Date:**________ **B.P.**________