Medical History Supplement for Antibiotic Prophylaxis

Patient Name:_____

Section 1

Have you had the following?

Joint replacement Yes _____No _____
Complications with joint replacement Yes _____No _____
Pins or plates placed during surgery Yes _____No _____
Artificial bones Yes _____No _____
If yes to any of the above, please list name and telephone number of Orthopedic Surgeon:

Name_____ Phone number_____

Section 2

Have you ever been diagnosed with the following conditions?

A history of endocarditis Yes _____No _____
Heart murmur Yes _____No _____
Mitral Valve prolapse Yes _____No _____
Congenital heart disease/defect Yes _____No _____
Heart surgery/repair of any kind including valve repair, shunts, transplant, pacemaker
Yes _____No _____
Heart attack Yes _____No _____
Stroke Yes _____No _____
Rheumatic Heart Disease or Rheumatic Fever Yes _____No _____
Scarlet fever Yes _____No _____
If yes to any of the above, please list name and telephone number of Cardiologist:

Name_____ Phone _____

Section 3

Are you receiving chemotherapy and have a central venous catheter
Yes _____No _____
Any organ transplant Yes _____No _____
Breast augmentation with implants Yes _____No _____
Any implant (other than to replace teeth) Yes _____No _____
If yes to any of the above, please list name and telephone number of Physician:

Name_____ Phone number_____

Section 4

Are you taking Bisphosphonate medication to treat Osteoporosis? Yes ____No ____

Any allergies, including metal, latex, and/or drugs? Yes ____No _____

If yes, please list allergies: _____
_____

Any other medical problems: _____
_____
_____

_____ _____
Signature of Patient/Parent or Guardian (if over 18) Date

_____
Home Address City State Zip

_____
Phone

_____
Email Address

_____ _____
Dentist Signature Date