



the center for  
**AESTHETIC & RESTORATIVE**  
 dentistry

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## Medical History

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Please indicate which of the following you have had, or have at present. Circle Yes or No for each item.

Heart Disease/Attack	Yes	No	Ulcers	Yes	No	Hepatitis	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Kidney Trouble	Yes	No
Heart Murmur	Yes	No	Thyroid Problem	Yes	No	Venereal Disease	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No	A.I.D.S./HIV Positive	Yes	No
Low Blood Pressure	Yes	No	Epilepsy or Seizures	Yes	No	Chemotherapy	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Tumors	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Blood Transfusion	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Osteoporosis	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Fainting/Dizzy spells	Yes	No
Latex Glove Sensitivity	Yes	No	Bruise easily	Yes	No	Liver Disease	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Yellow Jaundice	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Neurological Disorders	Yes	No
Diet/Special/Restricted	Yes	No	Radiation Therapy	Yes	No	Fever blisters/canker sores	Yes	No

**Are you allergic to:**

Penicillin	Yes	No
Codeine	Yes	No
Aspirin	Yes	No
Sulfa	Yes	No
Local Anesthetics	Yes	No
Other: _____		

**For Women: Are you:**

Pregnant?	Yes	No
Taking Birth control pills?	Yes	No
On Medicine for Menopause?	Yes	No

**Medication - Please list name, dosage & necessity:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any other important information concerning your health which is not listed above.

\_\_\_\_\_

\_\_\_\_\_

Have you ever been told to premedicate with antibiotics prior to receiving dental care? Yes No

Do you have any artificial joints (i.e. hip, knee, etc.) Yes No

Have you taken daily cortisone medication (Prednisone) in the past year? Yes No

Do you smoke tobacco? Yes No If yes, # per day \_\_\_\_\_ Do you chew tobacco? Yes No

Are you on coumadin or blood thinners? Yes No

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency to release information to you.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_