MEDICAL HISTORY

Name_____Birthdate_____File#_____

1. The name and address of your physician is_____

2. Date of your last physical exam (month/year)_____

3. Are you currently under the care of a physician?..... Yes No
   If yes, what is the condition being treated?_____

4. Have you ever had any serious illness, operation or hospitalization?..... Yes No
   If yes, please list:_____

5. Are you currently taking any medicine(s) including non-prescription or herbal supplements?..... Yes No
   If yes, please list:_____

6. Do you have an allergy or sensitivity to any medications and/or anesthetics?..... Yes No
   If yes, please list:_____

7. Do you have a latex allergy?..... Yes No

8. Do you have high or low blood pressure?..... Yes No

9. Do you have or have you had cardiovascular disease, including heart trouble, heart attack, stroke, angina, irregular heart rhythm or rhythm regulating device (i.e. pacemaker, defibrillator) vascular grafts or shunts, coronary insufficiency/occlusions, congenital heart defect, arteriosclerosis, or heart or blood vessel problems? Yes No
   If yes, which type?_____Date_____

10. Do you have a damaged or artificial heart valve(s) or a history of heart murmur or rheumatic fever?.... Yes No

11. Do you have an artificial joint(s), prosthesis, or organ transplant?..... Yes No
    If yes, which type?_____Date_____

12. Do you have or have you had cancer?_____ Yes No
    If yes, which type and how was it treated?_____

13. Circle any of the following which you have had or have at present.

Abnormal Bleeding	Diabetes	Problems with Mental Health
Anemia	Epilepsy/Neurological Disease	Recent Unexplainable Weight Loss
Arthritis or Painful Joints	Fainting Spells or Seizures	Respiratory Problems/Emphysema
Asthma	Jaundice/Liver Disease	Sexually Transmitted Disease
Blood Disorder	Kidney Problems	Sinus Problems
Blood Transfusion – When?	Osteoporosis	Stomach Problems
Bronchitis	Persistent Cough	Tuberculosis
	Problems of the Immune System	

14. Do you have or have you had hepatitis?…… Yes No
If yes, which type?_____

15. Do you have AIDS or HIV infection?…… Yes No

16. Have you ever been tested for AIDS or HIV infection?…… Yes No

17. Do you use or have you used tobacco in any form?…….. Yes No
If yes, which type and what amount?_____

18. Do you have or have you had a history of alcohol and/or drug dependency?……... Yes No
If yes, which type? _____

19. Do you have or have you had an eating disorder?…… Yes No

20. Do you have any other medical disease, condition, or problems not listed above?…….. Yes No
If yes, please explain _____

WOMEN

21. Are you pregnant?…….. Yes No

22. Are you nursing?…… Yes No

23. Are you taking birth control pills? If yes, what _____ Yes No

DENTAL HISTORY

1. What is your primary dental concern? _____

2. How long since your last dental visit? _____

3. Your previous dentist's name _____

4. Have you ever had any unusual problems or complications with previous dental treatment?……. Yes No
If yes, explain _____

5. Have you ever had gum treatment or surgery? …… Yes No

I certify the above information is complete and accurate.

Signature of Patient or Guardian _____ Date _____

In case of emergency call _____ Relationship _____