Medical History

Name: _____ Date of Birth: _____ Sex: M / F Height: _____ Weight: _____

Please answer the following questions as they apply to you. Your answers are for our records only and are confidential.

Are you generally in good health? ……..… Yes No

Has there been a change in your health in the last year? …… Yes No

When was your last physical exam? _____/_____/_____

Are you under the care of a physician? …… Yes No

If so, for what condition? _____

Name, address, and phone of current physician

_____

_____

_____

Have you had any serious illnesses, significant operations, or hospitalizations within the past 5 years? Yes No

If so, please explain and date: _____

_____

_____

Are you taking any medications? (Non-prescription, homeopathic, or "natural" remedies including diet pills?) Yes No

If so, please list: _____

_____

Do you have or have you had any of the following diseases or problems?

Damaged heart valves, artificial valves, or heart murmur……. Yes No

Heart surgery, Rheumatic Heart Disease, or a Heart Pacemaker……... Yes No

Congenital Heart Lesions, or Rheumatic Fever…….. Yes No

Mitral Valve Prolapse…… Yes No

Heart trouble, heart attack, or angina…….. Yes No

High blood pressure, stroke, or arteriosclerosis……...…….. Yes No

Any other heart condition……... Yes No

If so, please explain_____

Chest pain upon exertion? …… Yes No

Shortness of breath after mild exercise? …… Yes No

Do your ankles swell? …… Yes No

Are you allergic to or have you had a reaction to:

Local Anesthetics…… Yes No

Penicillin or Antibiotics…….. Yes No

Sulfa Drugs……	Yes	No
Barbiturates or Sleeping Pills……	Yes	No
Aspirin……	Yes	No
Erythromycin……	Yes	No
Nitrous Oxide……	Yes	No
Iodine……	Yes	No
Codeine or other narcotics……	Yes	No
Latex or Rubber products……..	Yes	No
Other……..	Yes	No

If so, please list_____

_____

Allergies or Hay Fever……..	Yes	No
Sinus Trouble……..	Yes	No
Asthma……	Yes	No
Fainting Spells……	Yes	No
Diabetes……..	Yes	No
Hepatitis A, B, or C……	Yes	No
AIDS/ARC/HIV Positive……	Yes	No
Venereal Disease……	Yes	No
Jaundice, or Liver Disease……..	Yes	No
Frequent or recurring mouth sores……..	Yes	No
Thyroid Problems……..	Yes	No
Respiratory Problems, Emphysema, Bronchitis etc……..	Yes	No
Arthritis or painful swollen joints including jaw joint……	Yes	No
Artificial Joints……..	Yes	No
Stomach Ulcers Or Hyperacidity……	Yes	No
Glaucoma……	Yes	No
Kidney Trouble……	Yes	No
Tuberculosis……	Yes	No
Persistent cough or cough that produces blood……..	Yes	No
Persistent swollen neck glands……	Yes	No
Low blood pressure……	Yes	No
Epilepsy or seizures……	Yes	No
Neurological Disorders……..	Yes	No
Cancer ……..	Yes	No

Chemotherapy or Radiation treatment…….. Yes No

Nervousness……... Yes No

Psychiatric treatment…….. Yes No

Fever Blisters…… Yes No

Drug Addiction or Alcoholism…… Yes No

Cortisone medicine…….. Yes No

Any disease, drug, or transplant that has depressed your immune system…….. Yes No

Have you had abnormal bleeding…… Yes No

Do you bruise easily…….. Yes No

Have you ever required a blood transfusion…….. Yes No

Do you have any blood disorders like anemia……. Yes No

Have you ever been treated for a tumor or growth……. Yes No

Have you ever had cosmetic surgery…… Yes No

Are you wearing contact lenses?…… Yes No

Do you wish to talk with the doctor privately about anything?……. Yes No

Do you have any other conditions or diseases you think the doctor should know about?

If so, please explain_____

_____

_____

Women:

Are you pregnant or trying to become pregnant……. Yes No

Are you nursing?…… Yes No

Are you on birth control?…… Yes No

If so, what are you taking? _____

Do you have problems associated with your menstrual period?……. Yes No

If so, please explain_____

_____

I, _____ certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____