MEDICAL HISTORY

PATIENT'S NAME: _____

(Last) (First) (MI)

CIRCLE THE APPROPRIATE ANSWER. IF YOU DO NOT KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW." PLEASE WRITE "N/A" OR "NONE" FOR QUESTIONS THAT DO NOT APPLY TO YOU.

1. Physician's Name: _____ Phone: _____
   Address: _____
2. Are you presently under a physician's care? ……..…..…. YES NO
   How Long? _____ Why? _____
3. When was your last complete physical exam? _____
4. (Women only) Are you pregnant or suspect that you may be? ……... YES NO
5. (Women only) Do you use any birth control medications? ……..……..... YES NO
6. Do you smoke? ……....……. YES NO
   Use snuff? ……. YES NO
   Use any other forms of tobacco? ……..……...…. YES NO
7. Do you consume alcoholic beverages? …….....…. YES NO
   How often? _____
8. Do you habitually use controlled substances? ……..... YES NO
9. Have you had psychiatric treatment? …… YES NO
10. Have you ever had any major surgery or serious illness? ……. YES NO
    Please explain: _____

PLEASE LIST ANY MEDICATIONS THAT YOU ARE PRESENTLY TAKING: _____
_____

PLEASE LIST ANY HEALTH RELATED, OR HERBAL SUBSTANCES THAT YOU ARE PRESENTLY TAKING:
_____

PLEASE LIST ANY ALLERGIES THAT YOU MAY HAVE (including penicillin, codeine, latex, metals, seasonal, etc.):
_____
_____

DO YOU REQUIRE AN ANTIBIOTIC PRE-MEDICATION FOR YOUR DENTAL APPOINTMENTS? …….. YES NO

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY)

AIDS
Allergies
Anemia
Arthritis or Rheumatism
Asthma
Artificial Heart Valve
Artificial Joint Replacement
Artificial Prosthesis
Blood Disorders
Cancer
Chemotherapy
Chest Pain
Diabetes
Dizziness
Epilepsy/Seizures
Excessive Bleeding
Fainting
Glaucoma
Heart Murmur (including MVP)
Heart Disease
High Blood Pressure
Hepatitis or Liver Disease
HIV Positive
Kidney Problems
Leukemia
Liver Problems
Low Blood Pressure
Lung Problems
Pacemaker
Radiation Therapy
Respiratory Problems
Rheumatic Fever
Sinus Problems
Stomach Problems
Stroke
Thyroid Problems
Tuberculosis (TB)
Tumor
Venereal Disease

Please list any additional health concerns you may have that were not listed above:

_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S (GUARDIAN SIGNATURE) _____ DATE _____

DENTIST SIGNATURE _____ DATE _____