MEDICAL HISTORY

PATIENT NAME _____ DATE _____

1. Are you in good health? ..... YES NO
2. Has there been any change in your general health in the last year? ..... YES NO
3. My last physical examination was on: _____
4. Are you under a physicians care? Why? _____ YES NO
5. The name, address and phone # of my physician is: _____

   _____
6. Have you ever had any serious illness, operation or hospitalization? ..... YES NO
   If so, please list and date, starting with the most recent: _____

   _____
7. Have you ever had a serious injury to your head or neck? Discuss _____

   _____
8. Are you taking any of the following? Please check yes or no.

YES	NO		YES	NO		YES	NO	
___	___	Antibiotics or sulfa drugs	___	___	Aspirin	___	___	Tranquilizers
___	___	Anticoagulants (blood thinners)	___	___	Insulin, Orinase or similar drug	___	___	Nitroglycerin
___	___	High blood pressure medication	___	___	Digitalis or drugs for heart trouble	___	___	Cortisone (steroids
___	___	Antihistamines	___	___	Oral contraceptive/hormonal therapy	___	Other (please list)	_____

_____

_____

_____

_____

9. Are you allergic or have you reacted adversely to any of the following? Please check yes or no.

YES	NO		YES	NO		YES	NO		YES	NO	
___	___	Penicillin or other antibiotics	___	___	Aspirin	___	___	Codeine	___	___	Local anesthetic
___	___	Barbiturates, sedatives, sleeping pills	___	___	Iodine	___	___	Acrylic	___	___	Sulfa drugs
___	___	Latex rubber	___	___	Metal	___	Other	_____			

10. Do you now have or have you ever had any of the following? Please check yes or no.
    *If you answer yes to any of the starred conditions, PLEASE CALL PRIOR TO APPOINTMENT - pre-medication may be required.

YES	NO		YES	NO		YES	NO	
___	___	Heart Trouble/Disease	___	___	Sickle Cell	___	___	Stomach/Intestinal Disease
___	___	Heart Murmur*	___	___	Hemophilia	___	___	Acid Reflux
___	___	Irregular Heart Beat	___	___	Leukemia	___	___	Ulcers
___	___	Angina/Chest Pain	___	___	Blood Transfusion	___	___	Unexplained Weight Loss
___	___	Congenital Heart Disorder	___	___	Asthma	___	___	Frequent Diarrhea
___	___	Mitral Valve Prolapse*	___	___	Lung Disease	___	___	Hypoglycemia
___	___	Scarlet Fever	___	___	Emphysema	___	___	Liver Disease
___	___	Rheumatic Fever*	___	___	Sinus Trouble	___	___	Hepatitis A
___	___	Artificial Heart Valve*	___	___	Hay Fever	___	___	Hepatitis B or C
___	___	Heart Pace Maker	___	___	Allergies	___	___	Jaundice
___	___	Heart Surgery*	___	___	Hives or Skin Rash	___	___	Kidney Problems
___	___	High Blood Pressure	___	___	Tuberculosis	___	___	Renal Dialysis
___	___	Low Blood Pressure	___	___	Persistent Cough	___	___	Thyroid Disease
___	___	Pain in chest w/exertion	___	___	Cough up blood	___	___	Arthritis/Gout
___	___	Short of breath w/exercise	___	___	Cancer	___	___	Rheumatism
___	___	Ankles swell	___	___	Radiation Treatments	___	___	Artificial Joint*
___	___	Short of breath or dizziness	___	___	Chemotherapy	___	___	Venereal Disease*
		when lying down	___	___	Diabetes	___	___	Aids/HIV Positive
___	___	Blood Disease	___	___	Excessive Thirst	___	___	Drug Addiction
___	___	Anemia	___	___	Frequent dry mouth	___	___	Tumors or Growth
___	___	Cold Sores/Fever Blisters	___	___	Epilepsy/Seizures	___	___	Glaucoma
___	___	Stroke	___	___	Alzheimer's	___	___	Fainting/Dizziness
___	___	Psychiatric Care	___	___	Genital Herpes/Herpes	___	___	Alcohol Use
___	___	Eating Disorder	___	___	Tobacco Use	___	___	Recreational Drug Use

11. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ..... YES NO

12. Are you wearing contact lenses? ..... YES NO

13. Have you had any serious trouble with any previous dental treatment ..... YES NO

If so, explain: _____

14. Do you have any disease, condition or problem not listed previously, that you think we should know? ..... YES NO

If so, explain: _____

_____

_____

_____

WOMAN

15. Are you pregnant or trying to get pregnant? ..... YES NO

16. Are you nursing? ..... YES NO

17. Are you taking oral contraceptives? ..... YES NO

18. Do you have any problems associated with your menstrual period? ..... YES NO

To the best of my knowledge, all of the preceding answers are correct. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completing this form. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X_____ DATE _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor_____ DATE _____

Significant findings _____

_____

_____

Medical History Updates

DATE	CHANGES	PATIENT SIGNATURE	REVIEWED BY