MEDICAL HISTORY

1. Are you aware of any dental problems at this time?	YES	NO
2. When was your last dental visit?	YES	NO
3. Are you seen in a dental office on a regular basis?	YES	NO
4. Have you ever had an adverse or allergic reaction to any dental procedure	YES	NO
If yes, please describe: _____		
How can we help you today?		
5. Have you been under the care of a medical doctor during the past two years?	YES	NO
If yes, for what condition:		
Physician's name:	Phone #:	
Address:		
6. Have you been a patient in the hospital in the past two years?	YES	NO
7. Are you currently taking prescription medications, vitamins or herbal medications?	YES	NO
8. Are you allergic to any drugs or medications such as Penicillin, Codeine or Aspirin?	YES	NO
If yes, please list those drugs: _____		
9. Do you use tobacco products?	YES	NO

Check any of the following which you have had in the past or presently have:

Alcoholism		Drug Addiction		Latex Allergy	
Allergies or Hives		Epilepsy or Seizures		Liver Disease	
Anemia		Emphysema		Nervousness	
Angina Pectoris		Fainting or Dizzy Spells		Pain in Jaw Joints	
Arthritis		Glaucoma		Psychiatric Treatment	
Artificial Heart Valve		Hay Fever		Radiation or Cobalt Treatment	
Artificial Joint (Hip, Knee, etc.)		Heart Disease or Attack		Rheumatic Fever0	
Asthma		Heart Failure		Rheumatism	
Bisphosphonate Therapy		Heart Murmur		Scarlet Fever	
Therapy (Fosamax, Actinel, etc.)		Heart Pacemaker		Sickle Cell Disease	
Blood Transfusion		Heart Surgery		Sinus Trouble	
Bruise Easily		Hemophilia		Stroke	
Chemotherapy (Cancer, Leukemia)		Hepatitis A (infectious)		Thyroid Disease	
Cold Sores		Hepatitis B (serum)		Tuberculosis (TB)	
Congenital Heart Lesions		Herpes		Ulcers	
Cortisone Medicine		High Blood Pressure		Venereal Disease	
Cough		HIV/AIDS		Yellow Jaundice	
Diabetes		Kidney Trouble			

10. Do you have to stop physical activity because of pain in your chest?	YES	NO
11. Have lost or gained more than 10 pounds in the past year?	YES	NO
12. Do you ever wake up from sleep short of breath?	YES	NO
13. Has your medical doctor ever said that you have cancer or a tumor?	YES	NO
14. Do you have any disease, condition or problem that was not listed?	YES	NO

FOR WOMEN ONLY

Are you using birth control medication?				YES	NO
Are you pregnant?	YES	NO	If yes, what month?		

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform the Doctor at the next appointment without fail.

Patient's Name: Date:	Date:	Witness:
Signature of Responsible Party:	Relationship To Patient:	