PATIENT'S NAME_____ D.O.B _____

MEDICAL HISTORY

*Please check those conditions that **NOW** or **HAVE EVER** applied to you:*

Yes	No		Yes	No	
☐	☐	Heart Murmur or Congenital Heart Disease	☐	☐	Glaucoma
☐	☐	Mitral Valve Prolapse	☐	☐	Arthritis
☐	☐	Heart Attack or Angina	☐	☐	Joint Replacement
☐	☐	Heart Surgery or Heart Disease	☐	☐	Organ Transplant
☐	☐	Rheumatic Fever	☐	☐	Cancer
☐	☐	Heart Pacemaker/Artificial Heart Valve	☐	☐	Radiation Treatment
☐	☐	Abnormal Blood Pressure (High / Low)	☐	☐	Immunosuppression
☐	☐	Stroke	☐	☐	Convulsions or Epilepsy
☐	☐	Diabetes	☐	☐	Dizziness or Fainting Spells
☐	☐	Bleeding Problems or Hemophilia	☐	☐	Emotional problems, Depression, Mental Illness, Psychiatric Treatment
☐	☐	Blood Diseases, ie. Anemia			
☐	☐	Lung problems ie. COPD, emphysema, bronchitis	☐	☐	Venereal Disease
☐	☐	Asthma or shortness of breath	☐	☐	AIDS/ HIV positive
☐	☐	Tuberculosis	☐	☐	Herpes
☐	☐	Jaundice or Liver Disease	☐	☐	Headaches
☐	☐	Hepatitis	☐	☐	Sinus Trouble
☐	☐	Kidney Disease	☐	☐	Recent weight loss
☐	☐	Ulcers, stomach or intestinal problems	☐	☐	Are you or do you suspect you are pregnant?
☐	☐	Thyroid Disease			

Please answer the following questions:

Are you currently under the care of a physician? _____ Physician's name _____

When was your last complete physical exam? _____

Have you had a serious illness or major surgery? _____

Are you taking any medications now or taken any recently? _____

If yes, please list prescription and non-prescription drugs, herbal medications or supplements.

_____

_____

Have you had an adverse reaction to penicillin, antibiotics, anesthetics or other medications? _____

Have you had any complications or allergic reactions to dental treatment? _____

Are you sensitive/allergic to latex or any metals? _____

Do you have any additional allergies? _____

Do you now or have you ever used tobacco products? _____

If you currently use tobacco, are you interested in quitting? _____

Do you have a history of chemical dependency? _____

Do you use recreational drugs? _____

Is there anything else we should know about your health that we have not covered in this form? _____

Would you like to speak to the Doctor privately about any problem? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____