

Name _____

MEDICAL HISTORY

CIRCLE

- YES NO Are you having pain or discomfort at this time?
- YES NO Do you feel nervous about having dental treatment?
- YES NO Have you ever had a bad experience in the dental office?
- YES NO Are you in good general health?
- YES NO Have you been under the care of a medical doctor during the past two years? If yes, for what? _____

Physician's Name _____ Phone _____

- YES NO Have you been a patient in the hospital during the past two years? For what? _____

Circle any of the following which you have had or have at present:

- | | | | |
|-------------------|----------------------|-----------------------|------------------------------|
| Abnormal bleeding | Diabetes | Mitral Valve Prolapse | Rheumatic Fever |
| Alcohol abuse | Difficulty Breathing | Pace Maker | Seizures |
| Allergies | Drug Abuse | Pre-Medicare | Sexually Transmitted Disease |
| Anemia | Emphysema | High Blood Pressure | Sinus Problems |
| Arthritis | Epilepsy | Low Blood Pressure | Stroke |
| Artificial Bones | Fainting Spells | Hemophilia | Surgery |
| Asthma | Fever Blisters | Hepatitis | Thyroid Problems |
| Blood Disorder | Frequent Headaches | Kidney Problems | Tuberculosi |
| Cancer | Glaucoma | Liver Disease | Ulcers |
| Radiation Therapy | HIV + AIDS | NSAID Sensitivity | Prostrate Problems |
| Colitis | Hay Fever | Pneumocystitis | |
| Contact Lenses | Heart Condition | Psychiatric Problems | |

Circle if you have allergic reaction to any of the following:

- | | | | | |
|---------|---------|--------------------|--------------|--------------|
| Aspirin | Codeine | Dental Anesthetics | Erythromycin | Jewelry |
| Latex | Metals | Penicillin | Tetracycline | Other: _____ |

- YES NO Are you taking any medications or drugs currently, including regular doses of Aspirin or over-the-counter herbal medicines? If yes please list _____

- YES NO When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath?
- YES NO Do your ankles swell during the day?
- YES NO Do you use more than 2 pillows to sleep?
- YES NO Have you lost or gained more than 10 pounds in the past year?
- YES NO Do you have any disease, condition, or problems not listed? What? _____

- YES NO Do you smoke?

WOMEN: Are you pregnant or think you may be pregnant? YES _____ weeks NO Nursing? YES NO
 WOMEN: Do you use birth control medications? YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If there have any change in my health, or if my medication change, I will inform this office at my next appointment.

Signature of Patient or Guardian _____

Date _____

Reviewed by Dr. _____

Date _____