PATIENT NAME_____

MEDICAL HISTORY

Are you currently under the care of a medical doctor? Yes No If yes, for what?_____

_____

Physician's name:_____Telephone #:_____

Address:_____City:_____ State:_____Zip:_____

Date of last physical examination:_____

Have you had any serious illness or been hospitalized within the past five years? Yes No

If yes, please explain:_____

_____

Are you currently taking any medication(s), drug(s) or pill(s)? Yes No

If so, please list name(s) and dosage(s):_____

_____

Are you aware of having an allergic (or adverse) reaction to any of the following?

Local anesthetics..... Yes No
Penicillin or other antibiotic..... Yes No
Sulfa drugs..... Yes No
Barbiturates, sedatives or sleeping pills..... Yes No
Other_____

Aspirin..... Yes No
Iodine..... Yes No
Codeine or other narcotic..... Yes No
Latex..... Yes No

Indicate which of the following your have had or have at the present. < Circle 'Yes' or 'No' >

Heart (Surgery, Disease, Attack)	Yes	No	Artificial Joints (hip, knee, etc.)	Yes	No	Shortness of breath	Yes	No	Anemia	Yes	No
Chest Pain	Yes	No	Diabetes (Type I or II)	Yes	No	Stroke	Yes	No	Hemophilia	Yes	No
Congenital Heart Disease	Yes	No	Diet (Special/Restricted)	Yes	No	Glaucoma	Yes	No	Sickle Cell Disease	Yes	No
Heart Murmur	Yes	No	Ulcers/Stomach Disorders	Yes	No	Arthritis/Rheumatism	Yes	No	Bruise Easily	Yes	No
High Blood Pressure	Yes	No	Kidney Disease	Yes	No	Tumors/Cancer	Yes	No	Liver Disease	Yes	No
Low Blood Pressure	Yes	No	Thyroid Problems	Yes	No	Chemotherapy	Yes	No	Yellow Jaundice	Yes	No
Mitral Valve Prolapse	Yes	No	Allergies (pollen/mold/etc)	Yes	No	Radiation Therapy	Yes	No	Neurological Disorders	Yes	No
Artificial Heart Valve	Yes	No	Sinus Trouble	Yes	No	Hepatitis	Yes	No	Epilepsy/Seizures	Yes	No
Heart Pacemaker	Yes	No	Asthma	Yes	No	Venereal Disease	Yes	No	Fainting/Dizzy Spells	Yes	No
Rheumatic Fever	Yes	No	Emphysema	Yes	No	A.I.D.S.	Yes	No	Nervous/Anxious	Yes	No
Swollen Ankles	Yes	No	Chronic Cough	Yes	No	H.I.V. Positive	Yes	No	Psychiatric/Psychological Care	Yes	No
Cortisone Medicine	Yes	No	Tuberculosis	Yes	No	Blood Transfusion	Yes	No			

Have you lost or gained more than 10 pounds in the past year?..... Yes No
Have you taken REDUX or PHEN PHEN for weight loss?..... Yes No
Do you have or have had any disease, condition, or problem not listed?..... Yes No
If YES, please explain_____

_____

FEMALE PATIENTS: Are you pregnant? Yes (_____months) No Are you nursing? Yes No
Are you taking BIRTH CONTROL PILLS or HORMONAL THERAPY? Yes No

PATIENTS WHO ARE MINORS:

Please identify custodial parent or guardian – Name:_____

Address:_____Telephone#:_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature_____Date_____