

MEDICAL HISTORY:

Physician's Name _____

Address _____

Are you now under the care of a Physician? Yes No

If yes, for what reason _____

Are you presently taking any medications/drugs/pills? Yes No

Have you ever taken a prescription drug for weight loss (i.e. Phen Fen or Redux) Yes No

ALLERGIES:

Are you allergic (or have an adverse reaction) to: Check all that apply or check none

- Penicillin Codeine Local Anesthetic None
- Aspirin Other Antibiotics Other Medications or Substances

List medications including vitamins, herbal supplements, natural products or over-the-counter drugs taken routinely:

Are you sensitive or allergic to latex? Have you experienced itching, rash or wheezing after using latex gloves or handling a balloon? Have you had any unusual or unexplained reactions during a surgical procedure? Yes NO Explain _____

Do you have, or have you ever had any of the following: (mark yes or no)

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis(circle one)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Type A B C		
Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Ailments	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach disorders	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	GERD (gastric reflux)	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapsed	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone medicine	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorder	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive/AIDS/ARC	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol addiction	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Removal of Spleen	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Drug Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Implants	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>			
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>			

Dr. Comments

Do you currently smoke or use the following products?
 Cigarettes cigars pipe chew none

Have you used tobacco products in the past? Yes No How long ago? _____

WOMEN; Are you pregnant Yes No

Do you take any birth control medication Yes No

If yes, Please note _____

Do you drink alcoholic beverages? Yes No How much? _____ How often _____

Have you had any other serious illness, hospitalization or accident? Yes No

If yes, please explain _____

FOR PROVIDER USE ONLY

BP SCREENING: _____

Would you like to speak to the Doctor privately about any problems? Yes No

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, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Signature: _____

Date _____

Doctor Signature _____

Date _____