MEDICAL HISTORY

Name_____ Date of Birth_____

How is your overall health? Excellent [ ] Good [ ] Fair [ ]
Physician's Name: _____ General Dentist's Name _____
Do you have, or have you had any of the following medical problems: **Circle Either** Y (Yes) or N (No)

Y / N High Blood Pressure
Y / N Low Blood Pressure
Y / N Artificial Heart Valves
Y / N Angina/Chest Pain/Heart Problems
Y / N Asthma/Shortness of Breath/Cough Blood
Y / N Cancer/Chemotherapy/Radiation Treatment
Y / N Heart Attack/Stroke/Pacemaker
Y / N Rheumatic Fever
Y / N Heart Murmur
Y / N Artificial Joints
Y / N Hemophilia/Bleeding Disorders/Bruising
Y / N Severe Frequent Headaches
Y / N Kidney Problems/Urinary Problems

Y / N Psychiatric Problems
Y / N Depression
Y / N Epilepsy/Seizures/Fainting Spells
Y / N Diabetes/Low Blood Sugar
Y / N Thyroid/Gland Problems
Y / N Tuberculosis
Y / N Sexually Transmitted Disease
Y / N HIV/AIDS
Y / N Blood Transfusion
Y / N Glaucoma
Y / N Hepatitis/Liver Disease/Jaundice
Y / N Ulcers/Colitis/Blood in Stool
Y / N Emphysema

Other, Not Mentioned Above _____
Are you taking any medications, prescription or non-prescription, now or within the last year? Y / N
Please list name(s) of medications: _____
_____

Are you allergic to any of the following:

Y / N Local Anesthesia (Novocaine)
Y / N Penicillin or Other Antibiotics
Y / N Codeine
Y / N Latex

Y / N Iodine
Y / N Sulfa Drugs
Y / N Aspirin
Y / N Sedatives

Y / N Eggs/Soy
Y / N Other _____
_____

Does your immediate family medical history include any of the following (Please Circle) Heart Disease / Cancer / Hemophilia / High Blood Pressure / Diabetes
Are you under medical treatment now? Y / N For what? _____
Have you ever been hospitalized? Y / N For what? _____
Have you ever had general anesthesia? Y / N
Are you wearing contact lenses? Y / N
Do you smoke or chew tobacco? Y / N How much? _____ For how long? _____
Do you drink alcohol? Daily [ ] Occasionally [ ] Never [ ]
Do you take recreational drugs? Y / N
Do you have, or have you had, problems with your jaw such as popping, clicking or inability to open? Y / N
Does snoring or irregular breathing disrupt your sleep or your partner's sleep? Y / N
Is there anything you would like to discuss in private? Y / N

FEMALES: Are you pregnant or think you may be pregnant? Y / N Are you nursing? Y / N
Are you taking birth control pills/shot? Y / N Date of last menstruation _____

I attest that the above information is true to the best of my knowledge and understand that it will be held in the strictest of confidentiality. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I understand and acknowledge that I am financially responsible for the services provided for myself or the above-named regardless or insurance coverage.

_____ _____
Signature (Parent or Legal Guardian if Patient is a Minor) **Date**

UPDATED HISTORY: [ ] PATIENT REPORTS NO CHANGES [ ] PATIENT REPORTS CHANGES _____
PT'S INITIALS _____ ASST'S INITIALS _____ DR'S INITIALS _____ DATE _____

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PT'S INITIALS _____ ASST'S INITIALS _____ DR'S INITIALS _____ DATE _____