PATIENT NAME: _____ DATE OF BIRTH: _____

PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE: _____

Have you ever been **hospitalized** or had a major operation? _____

Have you ever had a serious injury to your head or neck? _____

Pain in jaw joints? Frequent headaches? _____

Please list all **medications** you take. Include prescribed, over-the-counter, herbal, recreational: _____

_____

Are you **allergic to any medications** or substances? What was your reaction? _____

Aspirin Penicillin Codeine Acrylic Metal Sulfa Other _____

Women are you: Pregnant/trying to conceive? Nursing? Oral Contraceptives?

Do you now have or have you ever had any of the following? Please check yes or no for each:

	YES	NO		YES	NO		YES	NO
HEART DISEASE/SURGERY			UNEXPLAINED FEVER			AIDS/HIV POSITIVE		
IRREGULAR HEART BEAT			BRUISE EASILY/BLOOD DISEASE			ALCOHOLISM/DRUG ADDICTION		
ANGINA/CHEST PAIN			ANEMIA			HERPES/COLD SORES		
HEART ATTACK/FAILURE			EXCESSIVE BLEEDING			VENEREAL DISEASE		
CONGENITAL HEART DISORDER			HEMOPHILIA (BLEEDING PROBLEM)			CANCER/TUMORS/GROWTHS		
BACTERIAL ENDOCARDITIS*			LEUKEMIA			RADIATION/CHEMOTHERAPY		
ARTIFICIAL HEART VALVE*			STOMACH/INTESTINAL DISEASE			EPILEPSY/SEIZURES/CONVULSIONS		
HEART PACEMAKER			ACID REFLUX/GERD			SINUS TROUBLE		
STROKE			THYROID DISEASE			LUNG DISEASE		
KIDNEY PROBLEMS			FAINTING OR DIZZINESS			ASTHMA		
RENAL DIALYSIS			HIVES OR RASH			COPD		
DIABETES			ARTHRITIS/GOUT			TUBERCULOSIS		
HYPOGLYCEMIA			CORTISONE MEDICINE			LIVER DISEASE		
ALZHEIMERS/DEMENTIA			ARTIFICIAL JOINT			HEPATITIS B OR C		
HIGH BLOOD PRESSURE			OSTEOPOROSIS			NERVOUS ABOUT DENTAL CARE		
LOW BLOOD PRESSURE			EVER TAKEN BISPHOSPHONATES?					

Any other problems not listed above? _____

Have you ever **SMOKED?** YES NO If yes, what? _____ How much per day?_____ How many years?_____

If you checked yes above to **ASTHMA**: What causes an attack? _____ Do you carry an inhaler? _____ Where? _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at my next appointment without fail.

_____ _____

PATIENT SIGNATURE (PARENT OR GUARDIAN) DATE

Reviewed by the doctor _____ Date _____ BP _____ Pulse _____

I HAVE READ MY MEDICAL HISTORY ABOVE AND CONFIRM THAT IT ADEQUATELY STATES PAST AND PRESENT CONDITIONS.

Date	Exceptions	Patient Signature	BP	PULSE	Reviewed By
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____