MEDICAL HISTORY

Do you have a personal physician? Yes: ☐ No: ☐ Physician's Name: _____

Physician's Phone: _____ Date Of Last Visit: _____

Your current physical health? Good: ☐ Fair: ☐ Poor: ☐ Currently under the care of a physician? Yes: ☐ No: ☐

Please Explain: _____

Do you use tobacco in any form? Yes: ☐ No: ☐ Any metal rods, pins or implants placed? Yes: ☐ No: ☐

Are you taking any medications? Yes: ☐ No: ☐

Please list each one:

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?

Yes	No	CONDITIONS
☐	☐	Abnormal bleeding
☐	☐	Alcohol abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina pectoris
☐	☐	Arthritis
☐	☐	Artificial heart valve
☐	☐	Asthma
☐	☐	Blood transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Colitis
☐	☐	Congenital heart disease
☐	☐	Diabetes
☐	☐	Difficulty breathing
☐	☐	Drug abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial surgery
☐	☐	Fainting spells
☐	☐	Fever blisters
☐	☐	Frequent headaches

Yes	No	CONDITIONS
☐	☐	Glaucoma
☐	☐	HIV + AIDS
☐	☐	Heart attack
☐	☐	Heart murmur
☐	☐	Heart surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High blood pressure
☐	☐	Joint replacement
☐	☐	Kidney problems
☐	☐	Liver disease
☐	☐	Low blood pressure
☐	☐	Mitral valve prolapse
☐	☐	Pace maker
☐	☐	Psychiatric problems
☐	☐	Radiation therapy
☐	☐	Rheumatic fever
☐	☐	Seizures
☐	☐	Sexual transmitted disease
☐	☐	Shingles

Yes	No	CONDITIONS
☐	☐	Sickle cell disease
☐	☐	Sinus problems
☐	☐	Stroke
☐	☐	Thyroid problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Yes	No	**ALLERGIES**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry / Metals
☑	☐	Latex
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Other

Yes	No	IF FEMALE, PLEASE ANSWER
☐	☐	Taking birth control pills?
☐	☐	Are you pregnant?
		If so, how many weeks? _____
☐	☐	Are You Nursing?

Person to contact in case of emergency: _____ Relationship: _____

Address: _____ Phone Number: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my medical status since dentist and staff will rely on this information for treating me.

Signature: _____ Date: _____