MEDICAL HISTORY

Patient's Name____
(Last) (First) (MI)

CHECK THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON"T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name: ______________________________ Phone: ( ) __________________
2. Address: ____
3. Are you presently under a physician's care? YES ____ NO ____ How Long? __________________
4. When was your last complete physical exam?____
5. (Women only) Are you pregnant or suspect that you may be? YES ____ NO ____
6. (Women only) Do you use any birth control medications? YES ____ NO ____
7. Do you consume alcoholic beverages? YES ____ NO ____ How often? ______________________
8. Do you habitually use controlled substances? YES ____ NO____
9. Have you had psychiatric treatment? YES ____ NO ____
10. Have you ever had any major surgery or serious illness? YES ____ NO ____ Please explain:______
____

PLEASE LIST ANY MEDICATIONS THAT YOU ARE PRESENTLY TAKING:_______________
____
____

PLEASE LIST ANY HEALTH RELATED, OR HERBAL SUBSTANCES THAT YOU ARE PRESENTLY
TAKING:____

PLEASE LIST ANY ALLERGIES THAT YOU MAY HAVE (including penicillin, codeine, latex, metals, seasonal, etc.):____
____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY)

AIDS	DIZZINESS/FAINTING	LOW BLOOD PRESSURE
ANEMIA	EPILEPSY/SEIZURES	LUNG PROBLEMS
ARTHRITIS OR RHEUMATISM	PACEMAKER	EXCESSIVE BLEEDING
ASTHMA	GLAUCOMA	RADIATION THERAPY
ARTIFICIAL HEART VALVE	HEART MURMUR	RESPIRATORY PROBLEMS
ARTIFICIAL JOINT REPLACEMENT	HEART DISEASE	RHEUMATIC FEVER
BLOOD DISORDERS	HIGH BLOOD PRESSURE	STOMACH PROBLEMS
CANCER	HEPATITIES OR LIVER DISEASE	STROKE
CHEMOTHERAPY	HIV POSITIVE	THYROID PROBLEMS
CHEST PAIN	TUBERCULOSIS (TB)	KIDNEY PROBLEMS
DIABETES	LEUKEMIA	TUMOR
LIVER PROBLEMS	VENEREAL DISEASE	SEVERE HEADACHES

Please list any additional health concerns you may have that were not listed above:
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I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S OR GUARDIAN'S
SIGNATURE ____DATE____________________

DENTIST'S
SIGNATURE____DATE____________________