DATE____________________

MEDICAL HISTORY

1. Name:______________________________________Age:______________ Date of Birth____________________
   Person to contact in case of emergency:______________________________ Phone:________________________
2. ( ) Married ( ) Single ( ) Widow ( ) Divorced__________ Occupation:______________________
3. Name & Address of personal physician:______________________________ Phone:________________________
4. Date of last medical check up?______________________________________
5. Are you under a physicians care now? Y / N If yes, please explain:______________________________
   ____
   ____
6. Do you have any major heath problems? Y / N If yes, please explain:
   ____
   ____
7. Have you had a serious illness or injury in the last 5 years? Y / N If yes, please explain:____________________
   ____
   ____
8. Please list any medication or pills that you are now taking:

Medication	Dosage	Frequency Taken	Reason for Taking

9. Are you allergic or have you reacted adversely to any of the following:

Y / N Penicillin	Y / N Metals	Y / N Fluoride	Y / N Xylocaine
Y / N Erythromycin	Y / N Aspirin	Y / N Keflex	Y / N Demerol
Y / N Tetracycline	Y / N Darvocet	Y / N Valium	Y / N Nitrous Oxide
Y / N Latex	Y / N Codeine	Y / N Novocaine	Y / N Others________________

10. Have you ever had an unusual reaction to a local anesthetic? Y / N If yes, explain__________________________
    ____
11. Has your physician or another dentist ever recommended the use of an antibiotic before dental appointments? Y / N
    ____
12. Have you ever had a dependency on alcohol or drugs? Y / N____
13. Do you smoke or use other forms of tobacco? Y / N____
14. Do you use recreational drugs? Y / N____
    Note: The use of recreational drugs combined with normal dental procedures can result in death.
15. Do you exercise regularly? Y / N____
16. Do you lead a high-stress lifestyle? Y / N____

FOR WOMEN:

1. Is there any chance that you are pregnant? Y / N
2. Are you taking birth control pills? Y / N
3. Are you in, or have you been through menopause? Y / N

Over

Have you ever been diagnosed or treated for:

Y / N heart failure	Y / N pacemaker	Y / N stroke or aneurysm	Y / N shortness of breath
Y / N heart disease	Y / N mitral valve prolapse	Y / N sudden loss of vision	Y / N sleep in upright
Y / N heart attack	Y / N heart murmur	Y / N palpitations	Y / N Scarlet Fever
Y / N angina (chest pain)	Y / N congenital heart lesions	Y / N heart fluttering	Y / N Rheumatic heart
Y / N heart surgery	Y / N Rheumatic Fever	Y / N swollen ankles	
Y / N artificial heart valve	Y / N high blood pressure	Y / N congestive heart disease	
Y / N blood disorder	Y / N Leukemia	Y / N frequent nose bleeds	Y / N blood transfusion
Y / N Hemophilia	Y / N Sickle Cell Anemia	Y / N bruise easily	
Y / N Anemia	Y / N prolonged bleeding	Y / N blood test with unusual result	
Y / N Asthma	Y / N Tuberculosis	Y / N chronic cough	Y / N hay fever
Y / N wheezing	Y / N Pneumonia	Y / N cough up blood	
Y / N shortness of breath	Y / N Emphysema	Y / N collapsed lung	
Y / N artificial joint	Y / N organ transplant		
Y / N Epilepsy	Y / N paralysis	Y / N migraine headaches	Y / N impaired vision
Y / N seizures	Y / N neuralgia	Y / N head injury	
Y / N dizzy spells	Y / N frequent headaches	Y / N hearing problems	
Y / N clinical depression	Y / N anxiety	Y / N psychiatric treatment	Y / N hives
Y / N ulcers	Y / N cirrhosis	Y / N chronic diarrhea	Y / N kidney disease
Y / N colitis	Y / N Hepatitis A, B, C	Y / N blood in urine/stools	
Y / N liver disease	Y / N Jaundice	Y / N parasites	
Y / N AIDS	Y / N HIV Positive	Y / N veneral disease	Y / N Herpes
Y / N Diabetes	Y / N adrenal problems	Y / N cancer	Y / N Lupus
Y / N abnormal thirst	Y / N thyroid problems	Y / N tumors	Y / N back/neck problems
Y / N sores that don't heal	Y / N Multiple Sclerosis	Y / N chemotherapy	Y / N skin disease
Y / N swollen glands	Y / N Fibromyalgia	Y / N radiation treatment	Y / N recent weight change
Y / N Hodgkin's Disease	Y / N sleep disorder	Y / N arthritis	Y / N restricted diet

FOR ALL PATIENTS:

Do you have any diseases, conditions or anything else not listed above. If so, please describe:________________
____
____

To the best to my knowledge, all of the preceding answers are true and correct. If I have any change in my health or if my medications change, I will inform the doctor or hygienist at my next appointment.

______________________________ ____

Date Signature of Patient, Parent or Guardian

Updates:__________ __________ __________ __________ __________ __________ __________

__________ __________ __________ __________ __________ __________ __________

__________ __________ __________ __________ __________ __________ __________

__________ __________ __________ __________ __________ __________ __________