MEDICAL HISTORY

NAME ____

Last First MI Date

CIRCLE THE APPROPRIATE ANSWER

COMMENTS

1. Physicians name ______________________________
   Address ______________________________
   ____
2. Have you ever had a serious illness or operation?................................Yes No
   If so, explain ______________________________
   ____
3. Are you under a physicians care?.. Yes No
4. Are you taking any prescription or over the counter medications? Yes No
   List Medications ______________________________
   ____
5. Are you allergic to any medications?..Yes No
   List Medications ______________________________
   ____
6. Do you have a latex allergy?.. Yes No
7. Do you have any heart problems ? .... Yes No
8. Do you have a pacemaker or artificial valve? .... Yes No
9. Do you have a heart murmer or Mitral Valve Prolapse?........................ Yes No
10. Have you ever had rheumatic fever?.. Yes No
11. Have you ever had surgery, radiation treatment, for a tumor,
    growth or other condition?.. Yes No
12. Do you have high or low blood pressure?.. Yes No
13. Do you have any artificial joints or prosthesis?.......................................Yes No
14. Do you have anemia, leukemia , etc ?.. Yes No
15. Do you bleed excessively after being cut?.. Yes No
16. Do you have any stomach problems ? .... Yes No
17. Do you have any liver problems ?.. Yes No
18. Do you have any kidney problems? .... Yes No
19. Are you diabetic?..Yes No
20. Do You have asthma?... Yes No
21. Do you have epilepsy or seizure disorders?..Yes No
22. Are you HIV positive or do you have AIDS?... .Yes No
23. Do you have or have you ever had hepatitis?..Yes No
24. Do you have or have you had T.B.? ....Yes No
25. Do you or have you ever used any tobacco products............................Yes No
26. Do you consume alcoholic beverages?...Yes No
27. Women- are you pregnant or suspect you may be?...............................Yes No
28. Do you have any disease, condition, or problem not listed above?
    If so, explain ______________________________
    ____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient signature ______________________________ Date__________

Dentist's signature ______________________________ Date__________