Medical History

Name:_____ Date: _____

Address: _____ Birthdate: _____

City/State/Zip: _____ S. S. #: _____

For the following questions, circle *yes* or *no*. Your answers are for our records only and will be considered confidential. Please note that you may be asked additional questions regarding your health.

1. Date of last physical examination: _____
2. Are you currently under the care of a physician? YES NO
3. Your physician's name; _____
   Address/Phone #: _____
   _____
4. Have you had any serious illness, operations or hospital stays within the last 5 years? _____ YES NO
5. Please list all **medications** you are currently taking, including over the counter, non prescription drugs or herbal supplements.
   _____
   _____
   _____
6. **Do you have or have you ever had any of the following conditions?**

Anemia	YES	NO	Hemophilia	YES	NO
Artificial Bones/Joints	YES	NO	Hepatitis	YES	NO
Asthma	YES	NO	High Blood Pressure	YES	NO
Arthritis	YES	NO	HIV+ / AIDS	YES	NO
Abnormal Bleeding	YES	NO	Kidney Problems	YES	NO
Blood Transfusion	YES	NO	Low Blood Pressure	YES	NO
Cancer/Chemotherapy	YES	NO	Mitral Valve Prolapse	YES	NO
Congenital Heart Defect	YES	NO	Pacemaker	YES	NO
Diabetes	YES	NO	Mental Illness	YES	NO
Difficulty Breathing	YES	NO	Radiation Therapy	YES	NO
Drug/Alcohol Abuse	YES	NO	Rheumatic/Scarlet Fever	YES	NO
Emphysema	YES	NO	Severe Headaches	YES	NO
Epilepsy/Seizures	YES	NO	Shingles	YES	NO
Fever Blisters	YES	NO	Sinus Problems	YES	NO
Glaucoma	YES	NO	Stroke	YES	NO
Heart Attack	YES	NO	Tuberculosis (TB)	YES	NO
Heart Surgery	YES	NO	Ulcers/Colitis	YES	NO
Heart Murmur	YES	NO	History of Herpes Virus	YES	NO
Are you a smoker?	YES	NO			

   ***To your knowledge, do you have any condition which requires you to Pre-medicate before receiving dental treatment? **YES NO**

   If yes, what medication do you generally take?

   _____

   Your Pharmacy:_____ Phone #:_____

7. **Are you allergic to any of the following?**

Aspirin	Yes	No	Latex	Yes	No
Codeine	Yes	No	Penicillin	Yes	No
Dental Anesthetics	Yes	No	Tetracycline	Yes	No
Erythromycin	Yes	No	Other_____		

8. **FOR WOMEN:**
   Are you pregnant? Yes No Are you nursing? Yes No
   Are you taking Birth Control Pills? _____
9. Do you have any dental problems, concerns, or complaints?_____
10. Would you like information regarding teeth whitening? YES NO

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status. I will not hold my dentist, or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature:_____ Date: _____