MEDICAL HISTORY

Patient Name:_____ Birth Date:_____ Date:_____

Physician Name:_____ Physician #_____ Date of recent exam:_____

General Health: (please circle one) Excellent Good Fair Poor

			If yes, Please explain
1. Are you under a physician's care currently?	Y	N	
2. Have you been hospitalized or had any major operations?	Y	N	
3. Have you ever had serious head or neck injury?	Y	N	
4. List all medications you currently are taking?	Y	N	
5. Do you take or have taken Redux or Phen -Fen	Y	N	
6. Have you taken bisphosphonates, Fosamax, Boniva or Actonel for osteoporosis?	Y	N	
7. Are you on any special diet?	Y	N	
8. Have you lost or gained more than 10lbs in the past year?	Y	N	
9. Do you use any form of Tobacco?	Y	N	
10. Do you use controlled substances?	Y	N	

Are you allergic to any of the following?
Aspirin / Penicillin / Codeine / Local Anesthetics / Acrylic / Metal / Latex / Sulfa drugs / other:_____

Woman: Are you
Pregnant or trying to get pregnant? Yes No Taking Oral Contraceptives? Yes No Nursing? Yes No

Do you have or have you had any of the following:

AIDS/HIV Positive	Y	N	Diabetes	Y	N	Hemophilia	Y	N	Radiation Treatments	Y	N
Alzheimer's Disease	Y	N	Drug addiction	Y	N	Hepatitis A	Y	N	Recent Weight loss	Y	N
Anaphylaxis	Y	N	Easily Winded	Y	N	Hepatitis B or C	Y	N	Renal Dialysis	Y	N
Anemia	Y	N	Eating Disorder	Y	N	Herpes	Y	N	Rheumatic Fever	Y	N
Angina	Y	N	Emphysema	Y	N	High Blood Pressure	Y	N	Rheumatism	Y	N
Arthritis /Gout	Y	N	Epilepsy or Seizures	Y	N	High Cholesterol	Y	N	Scarlet Fever	Y	N
Artificial Heart Valve	Y	N	Excessive bleeding	Y	N	Hives or Rash	Y	N	Shingles	Y	N
Artificial Joint	Y	N	Excessive thirst	Y	N	Hypoglycemic	Y	N	Sickle Cell Disease	Y	N
Asthma	Y	N	Fainting spells/dizziness	Y	N	Irregular heartbeat	Y	N	Sinus Trouble	Y	N
Blood Disease	Y	N	Frequent cough	Y	N	Kidney problems	Y	N	Sleep Apnea/Snoring	Y	N
Blood Transfusion	Y	N	Frequent Diarrhea	Y	N	Leukemia	Y	N	Spina Bifida	Y	N
Breathing Problems	Y	N	Frequent headaches	Y	N	Liver disease	Y	N	Stomach/intestine disease	Y	N
Bruise Easily	Y	N	Gastric reflex	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Genital herpes	Y	N	Lung Disease	Y	N	Swelling of limbs	Y	N
Chemotherapy	Y	N	Glaucoma	Y	N	Mitral valve prolapse	Y	N	Thyroid disease	Y	N
Chest pain	Y	N	Hay fever	Y	N	Organ transplant	Y	N	Tonsillitis	Y	N
Cold Sores/Fever Blisters	Y	N	Heart attack/failure	Y	N	Osteoporosis	Y	N	Tuberculosis	Y	N
Congenital Heart Disease	Y	N	Heart murmur	Y	N	Pain in jaw joint	Y	N	Tumors or growths	Y	N
Convulsions	Y	N	Heart pacemaker	Y	N	Parathyroid disease	Y	N	Ulcers	Y	N
Cortisone Medicine	Y	N	Heart Trouble/disease	Y	N	Psychiatric care	Y	N	Venereal disease	Y	N
									Yellow Jaundice	Y	N

Have you ever had any serious illness or condition not listed above: Y N (if yes, explain)_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent or Guardian Date