

PATIENT'S NAME: _____
(Last) (First) (MI)

CIRCLE 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: _____
Address: _____
2. Are you presently under a physician's care? YES NO How Long? _____
Why? _____
3. When was your last complete physical exam? _____
4. (Women only) Are you pregnant or suspect that you may be? YES NO
5. (Women only) Do you use any birth control medications? YES NO
6. Do you smoke? YES NO Use snuff? YES NO Use any other forms of tobacco? 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 | Low Blood Pressure |
| Allergies | Epilepsy/Seizures | Lung Problems |
| Anemia | Excessive Bleeding | Pacemaker |
| Arthritis or Rheumatism | Fainting | Radiation Therapy |
| Asthma | Glaucoma | Respiratory Problems |
| Artificial Heart Valve | Heart Murmur (including MVP) | Rheumatic Fever |
| Artificial Joint Replacement | Heart Disease | Sinus Problems |
| Artificial Prosthesis | High Blood Pressure | Stomach Problems |
| Blood Disorders | Hepatitis or Liver Disease | Stroke |
| Cancer | HIV Positive | Thyroid Problems |
| Chemotherapy | Kidney Problems | Tuberculosis (TB) |
| Chest Pain | Leukemia | Tumor |
| Diabetes | Liver Problems | Venereal Disease |

DO YOU REQUIRE AN ANTIBIOTIC PRE-MEDICATION FOR YOUR DENTAL APPOINTMENTS? YES NO

Please list any additional health concerns you may have that were not listed above:

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S (OR GUARDIAN'S) SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

MEDICAL HISTORY