MEDICAL HISTORY

Patient's Name _____________________________________ Date of Birth _________________ Female/Male

Medical Doctor's Name ________________________________ Doctor's Phone ___________________

Please answer the following questions as completely as possible (circle "YES" or "NO")

1. Do you consider yourself to be in good health?..**YES NO**

2. Are you in pain now?...**YES NO**

3. Are you **now**, or have you **ever** been under a medical doctor's care within the past year?..**YES NO**
If yes, specify condition being treated ____

4. Do you take any medications, including prescriptions and birth control pills, or use medicated creams?............................**YES NO**
If yes, please specify **name** and **purpose** of medication: ____________________________________
____

5. Have you **ever** had (Check those that apply):……………………………………………………………………………**YES NO**
Heart Attack___ Diabetes ____ Rheumatic Fever___ Asthma ___ ANY blood disorder___ Cancer____
Bleeding/Sensitive Gums____ Hepatitis___ HIV/AIDS____ Tuberculosis____ Liver Disease____
Nervous Breakdown/Psychiatric Treatment____ Rheumatism____ Arthritis ____ Venereal disease ____
Kidney disease___ Immune system disorder____ Other disease? If so, please specify_________________

6. Do you **have or have you ever had** any heart problems or been told you have a heart murmur?.....................................**YES NO**

7. Do you **have or have you ever had** high blood pressure?...**YES NO**

8. Do you require antibiotic **pre-medication** for a heart condition, artificial valve or joint?...**YES NO**

9. Have you ever had an unusual reaction or are you allergic to any of the following (Check those that apply)……...……..**YES NO**
Penicillin___ Amoxicillin___ Aspirin ___ Acetaminophen ___ Ibuprofen ___ Codeine ___
Barbiturates ___ Sulfa drugs ___ Local Anesthetic (Please list) ___________________________________

10. Are you allergic to **LATEX** or have you ever had swelling of the lips after blowing up a balloon?................................**YES NO**

11. Do you have any other allergies? If yes, please describe: ____________________________________ ....**YES NO**

12. Have you ever received any counseling for excessive use of alcohol and/or prescription drugs?....................................**YES NO**

13. Do you bleed or bruise easily?...**YES NO**

14. How long ago did you last see a dentist? ____

15. Who was your previous dentist? ____

16. WOMEN: Are you pregnant? Due date: ____________________________..**YES NO**

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY KNOWLEDGE

Signature ____ **Date**____________________________
(Patient, legal guardian or authorized agent of patient)

Dr. Signature____ **Date**__________________________

6 month update: _______ **Date:** ______________ **6 month update:** _______ **Date:** ______________

6 month update: _______ **Date:** ______________ **6 month update:** _______ **Date:** ______________