

MEDICAL HISTORY

Patient: _____ **Birthdate:** _____ **Today's Date:** _____
Address: _____ **City:** _____ **Phone:** _____
Employer: _____ **Employer Address:** _____
Your current physical health is: Good Fair Poor **Physician's (Medical Doctor) Name:** _____

Please list any prescription, over-the-counter medicines, herbal or dietary supplements currently being taken and for what conditions:

_____ to treat _____ | _____ to treat _____
 _____ to treat _____ | _____ to treat _____

Have you ever had or are you currently experiencing any of the following diseases or medical problems? (Please circle Y or N)

Y N Abnormal Bleeding	Y N Glaucoma	Y N Psychiatric Problem
Y N Alcohol/Drug Abuse	Y N Hay Fever	Y N Radiation Treatment
Y N Alzheimer's Disease	Y N Heart Attack	Y N Rheumatic/Scarlet Fever
Y N Anemia	Y N Heart Disease	Y N Seizures
Y N Arthritis	Y N Heart Murmur	Y N Shingles
Y N Artificial Bones/Joints/Valves	Y N Heart Surgery	Y N Sickle Cell Anemia
Y N Asthma	Y N Hemophilia	Y N Sinus Problems
Y N Blood Transfusion	Y N Hepatitis	Y N Special Needs (explain)
Y N Breast implant/expander (placed during the last 12 months)	Y N Herpes/Fever Blisters	_____
Y N Cancer/Chemotherapy	Y N High Blood Pressure	_____
Y N Cholesterol	Y N HIV+/AIDS	Y N Stroke
Y N Colitis	Y N Kidney Problems	Y N Thyroid Problems
Y N Congenital Heart Defects	Y N Liver Disease	Y N Tuberculosis (TB)
Y N Diabetes	Y N Low Blood Pressure	Y N Ulcers
Y N Difficulty Breathing	Y N Mitral Valve Prolapse	Y N Venereal or Sexually Transmitted Disease
Y N Emphysema	Y N Pacemaker	Other _____
Y N Epilepsy	Y N Periodontal (Gum) Disease (past treatment)	
Y N Fainting Spells	Y N Pregnant (currently)	
Y N Frequent Headaches	Week # _____	

Please list hospitalizations (surgeries, emergency room) within the last year:

_____ to treat _____ | _____ to treat _____
 _____ to treat _____ | _____ to treat _____

Are you allergic to any of the following? If so, indicate what kind of reaction you had:

Y N Aspirin _____	Y N Metals _____
Y N Codeine _____	Y N Latex _____
Y N Dental Anesthetics _____	Y N Tetracycline _____
Y N Erythromycin _____	Y N Penicillin _____
Y N Jewelry _____	Y N Other _____

Do you smoke or use tobacco in any form? Yes No

Dental Issues. Please indicate if you wish to discuss treatment of the following:

Areas of pain or sensitivity Straightness of teeth Bleeding of Gums
 Bad Breath Whiteness of teeth Alternatives for existing dental work

Do you experience anxiety (fear) when receiving dental treatment? Yes No

Do you need antibiotics before dental treatment? Yes (Reason) _____ No

Office Use Only	
BP: ____/____	Pulse: _____

Signature of person completing form

Relationship if other than patient