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MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
 Name of medical physician _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? Poor Fair Good

HAVE YOU EVER HAD THE FOLLOWING?

Hospitalization for illness or injury	YES	NO	Diabetes	YES	NO
Allergic reaction to			Stomach or duodenal ulcer	YES	NO
Aspirin, ibuprofen, acetaminophen			Digestive disorders	YES	NO
Penicillin			Arthritis	YES	NO
Erythromycin			Glaucoma	YES	NO
Tetracycline			Contact lenses	YES	NO
Codeine			Head or neck injuries	YES	NO
Local anesthetic			Epilepsy or convulsions (seizures)	YES	NO
Fluoride			Viral infections and cold sores	YES	NO
Metals (gold, stainless steel)			Any lumps or swelling in the mouth	YES	NO
Latex			Hives, skin rash, hay fever	YES	NO
Any other medications			Venereal disease	YES	NO
Heart problems	YES	NO	Hepatitis - Type A B C D E	YES	NO
Heart murmur	YES	NO	HIV / AIDS	YES	NO
Rheumatic fever	YES	NO	Tumor, abnormal growth	YES	NO
Scarlet fever	YES	NO	Radiation therapy	YES	NO
High blood pressure	YES	NO	Chemotherapy	YES	NO
Low blood pressure	YES	NO	Emotional problems	YES	NO
A stroke	YES	NO	Psychiatric treatment	YES	NO
Artificial prosthesis (i.e., heart valve or joints)	YES	NO	Antidepressant medication	YES	NO
Anemia or other blood disorder	YES	NO	ARE YOU:		
Prolonged bleeding due to a slight cut	YES	NO	Presently being treated for any illness	YES	NO
Emphysema	YES	NO	Aware of a change in your general health	YES	NO
Tuberculosis	YES	NO	Often exhausted or fatigued	YES	NO
Asthma	YES	NO	Subject to frequent headaches	YES	NO
Sinus problems	YES	NO	A heavy smoker (one pack or more per day)	YES	NO
Kidney disease	YES	NO	Considered a touchy person	YES	NO
Liver disease	YES	NO	Often unhappy or depressed	YES	NO
Jaundice	YES	NO	Easily upset or irritated	YES	NO
Thyroid or parathyroid disease	YES	NO	Female - taking birth control pills	YES	NO
Hormone deficiency	YES	NO	Female - pregnant	YES	NO
High cholesterol	YES	NO	Male - prostate disorders	YES	NO

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

List any medications, herbal supplements and/or vitamins taken within the last two years:

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

PATIENT'S SIGNATURE _____ DATE _____

DOCTOR'S REMARKS _____

DOCTOR'S SIGNATURE _____

NOTE: If remitting electronically via email or fax, patient will sign and date at first office visit.