Last Name:	First	Middle

Please ✔ YES or NO to each question. If unsure of a question, please consult with the dentist or receptionist. **YES NO**

1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: ________ ☐ ☐
2. Have you been hospitalized in the past two years?________ ☐ ☐
3. When was your last visit to a Physician? ________ Last complete physical examination? ________
4. Have you recently, or are you presently, taking any PRESCRIPTION or NON-PRESCRIPTION drugs? Please list: ☐ ☐
   1. ________ 2. ________ 3. ________
   4. ________ 5. ________ 6. ________
5. Have you ever reacted adversely to any of the following? (Please circle.) ANTIBIOTICS - Penicillin, Erythromycin, Dalacin, Sulfa, or other antibiotics, ASPIRIN, VALIUM, CODEINE, NARCOTICS, LOCAL ANAESTHETIC (freezing), any other medicine: ________ ☐ ☐
6. Have you ever been advised against taking any specific type of medication? ________ ☐ ☐
7. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions? ________ ☐ ☐
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain: ________ ☐ ☐
9. Have you been advised by your Medical Doctor or Dentist to take antibiotics prior to dental treatment?________ ☐ ☐
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily?________ ☐ ☐
11. Do your ankles, feet or hands swell?________ ☐ ☐
12. Has your weight, appetite or energy level changed dramatically recently? ________ ☐ ☐
13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? ________ ☐ ☐
14. Have you tested HIV positive, or come in contact with the AIDS virus?________ ☐ ☐
15. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? ________ ☐ ☐
16. Have you ever had any injury or surgery to your face or jaws?________ ☐ ☐
17. Do you smoke or use any other forms of tobacco?________ ☐ ☐
18. Are you alcohol and/or drug dependent?________ ☐ ☐
    and, Have you received treatment?________ ☐ ☐
19. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

	YES	NO		YES	NO		YES	NO
Anemia	☐	☐	Heart disease or attack	☐	☐	Malignant Hyperthermia	☐	☐
Angina pectoris	☐	☐	Heart murmur	☐	☐	Metal allergy	☐	☐
Arthritis/rheumatism	☐	☐	Heart pacemaker	☐	☐	Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐	Heart rhythm disorder	☐	☐	Organ transplant/medical implant	☐	☐
Artificial joints (hip, knee)	☐	☐	Heart surgery	☐	☐	Psychiatric treatment	☐	☐
Blood disorders	☐	☐	Hepatitis A	☐	☐	Radiation treatment/chemotherapy	☐	☐
Bronchitis	☐	☐	Hepatitis B	☐	☐	Rheumatic/Scarlet fever	☐	☐
Cancer	☐	☐	Hepatitis C	☐	☐	Sickle cell disease	☐	☐
Circulation problems	☐	☐	HIV	☐	☐	Sinus trouble	☐	☐
Congenital heart lesions	☐	☐	High blood pressure	☐	☐	Stomach/intestinal problems	☐	☐
Cortisone/steriods	☐	☐	Low blood pressure	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Hodgkins disease	☐	☐	Thyroid disease	☐	☐
Emphysema	☐	☐	Hyper (Hypo) Glycemia	☐	☐	Tuberculosis	☐	☐
Epilepsy or seizures	☐	☐	Jaundice	☐	☐	Ulcers	☐	☐
Fainting or dizzy spells	☐	☐	Kidney disease	☐	☐	Other ________	☐	☐
Glandular disorders	☐	☐	Latex allergy	☐	☐	Other ________	☐	☐
Glaucoma	☐	☐	Liver disease	☐	☐	Other ________	☐	☐
Head/neck injuries	☐	☐	Lung disease	☐	☐	Other ________	☐	☐

20. WOMEN ONLY: Are you pregnant or suspect you may be? ________ ☐ ☐
    If yes, what is the expected delivery date? ________ Are you taking any birth control pills? ________ ☐ ☐

21. Do you currently have, or have you had in the past, any disease, condition or problem not listed above?________ ☐ ☐
22. Is there anything else about your health we should be made aware of?________ ☐ ☐
23. Do you wish to speak to the Doctor privately about any problem or medical condition? ________ ☐ ☐

MEDICAL HISTORY MEDICAL HISTORY UPDATES