MEDICAL HISTORY

Your Physician_____Type_____How Long_____
Office Address_____Zip_____Phone_____

DO YOU HAVE OR HAVE EVER HAD (circle)

1. Hospitalization for illness or surgery……. Yes No
2. Any allergic reaction to:
   a. aspirin…….. Yes No
   b. penicillin……..Yes No
   c. erythromycin……... Yes No
   d. tetracycline…… Yes No
   e. codeine…… Yes No
   f. sedatives, sleeping pills (barbiturates) Yes No
   g. dental anesthetic……Yes No
   h. any other medication……Yes No
   i. latex gloves……... Yes No
3. Hepatitis……Yes No
4. Jaundice (yellow skin and eyes)…….. Yes No
5. Epilepsy…… Yes No
6; Arthritis…… Yes No
7. Venereal disease…… Yes No
8. Rheumatic fever……...Yes No
9. Scarlet fever……Yes No
10. Anemia or other blood disorders…… Yes No
11. Prolonged bleeding due to a slight cut……Yes No
12. Kidney disease…….. Yes No
13. Diabetes……... Yes No
14. Stomach or duodenal ulcer…….. Yes No
15. Liver disease…….. Yes No
16. Tuberculosis……... Yes No
17. Emphysema…… Yes No
18. Thyroid or parathyroid disorders…… Yes No
19. Heart trouble……Yes No
20. Heart murmur…… Yes No
21. Arteriosclerosis…….. Yes No
22. High blood pressure…….. Yes No
23. Low blood pressure……Yes No
24. Excessively swollen ankles……..Yes No
25. Taken Phen-fen…… Yes No
25. A stroke……..…… Yes No
26. Shortness of breath on mild exertion……..Yes No
27. Chest pains on mild exertion……Yes No
28. Hives, skin rash, hay fever……... Yes No
29. Asthma…….. Yes No
30. Emotional problems or tension……..….Yes No
31. Psychiatric treatment……Yes No
32. A tumor or abnormal growth…….. Yes No
33. Medical radiation treatment……..Yes No
34. Glaucoma……..…… Yes No
35. Contact lenses……Yes No
36. Prostate disorders (if male)……... Yes No
37. Blood transfusions…… Yes No
38. Substance abuse (alcohol, drugs, IV drug)... Yes No
39. Immune deficiency syndromes (HIV, AIDS).. Yes No

ARE YOU

40. Presently being treated for any illness…….... Yes No
41. Taking any medication regularly now or within the past year…… Yes No
42. Aware of recent change in general health … Yes No
43. Aware of any recent weight change…..…. Yes No
44. Often thirsty…… Yes No
45. Urinating more than six times per day……. Yes No
46. Often exhausted and fatigued…… Yes No
47. Subject to frequent headaches…… Yes No
48. A smoker…… Yes No
49. Generally a nervous person…… Yes No
50. Often unhappy and depressed…….. Yes No

IF FEMALE, ARE YOU NOW:

51. Pregnant……...Yes No
52. Taking birth control pills or other hormones.. Yes No
53. Presently in the menopause (change of life). Yes No
54. Past menopause…… Yes No

PLEASE EXPLAIN FULLY ANY YES ANSWERS ABOVE

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IF THERE ARE ANY CHANGES IN MY MEDICAL HISTORY, I WILL NOTIFY THE DENTIST

PATIENT'S SIGNATURE_____DATE_____

Reviewed by_____Date_____ Reviewed by_____Date_____

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____