MEDICAL HISTORY

PATIENT NAME: _____

Last First Initial D.O.B.

CIRCLE

YES NO Are you having pain or discomfort at this time?
YES NO Do you feel nervous about having dental treatment?
YES NO Have you ever had a bad experience in the dental office?
YES NO Do you have any hearing problems?
YES NO Have you lost or gained more that 10 pounds in the past year
YES NO Are you on a special diet?
YES NO Do you exercise regularly?
YES NO Has your medical doctor ever said you have cancer or a tumor?
YES NO Have you ever had any excessive bleeding requiring special treatment?

Current Medications or Drugs:_____

_____

Vitamins, Supplements, Herbals: _____

Allergies:_____

Hospitalizations or surgeries within the last two years: _____

Circle any of the following, which you have had or have at present:

Heart Failure	Kidney Trouble	Tumor	Drug Addiction
Heart Attack or Heart Disease	Ulcers	Arthritis	Venereal Disease
Angina Pectoris	Headaches	Rheumatism	Cold Sores
High Blood Pressure	Emphysema	Glaucoma	Herpes
Heart Murmur	Cough	Pain in Joints	Epilepsy or Seizures
Congenital Heart Lesions	Tuberculosis	Bruise Easily	Fainting or Dizzy Spells
Artificial Heart Valve	Asthma	Excessive Bleeding	Nervousness
Heart Pacemaker	Hay Fever	Hemophilia	Psychiatric Treatment
Heart Surgery	Sinus Trouble	Sickle Cell	Eating Disorder
Artificial Joint	Diabetes	AIDS/HIV	
Anemia	Thyroid Disease	Hepatitis	
Stroke	Cancer or Chemotherapy	Liver Disease	

Any other disease, condition, or problem not listed here: _____

Do you smoke?_____

Women: Are you pregnant now?_____

What is your overall general health? **EXCELLENT GOOD FAIR POOR**

Family Physicians Name:_____

Address:_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. IfI ever change in my health, or if my medicines change, I will inform this office at my next appointment.

_____ _____

Date Signature of Patient, Parent or Guardian