Medical History

Please indicate which of the following you have had, or have at present. Circle the "yes" or "no"

Any Heart Conditions	Yes	No	Ulcers	Yes	No	Sickle Cell Disease	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lens	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Tuberculosis	Yes	No
Heart Pacemaker	Yes	No	Asthma	Yes	No	Hepatitis A,B or C	Yes	No
Rheumatic Fever	Yes	No	Hay Fever	Yes	No	Bruise easily	Yes	No
Arthritis/Rheumatism	Yes	No	Latex Sensitivity	Yes	No	Liver Disease	Yes	No
Cortisone Medicines	Yes	No	Allergies or Hives	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Sinus Troubles	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Radiation Therapy	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Restricted/Special)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Troubles	Yes	No	Tumors	Yes	No	Psychological Care	Yes	No
Parkinson	Yes	No	Crones	Yes	No	Cosmetic Surgery	Yes	No

Women: Are you Pregnant? Yes, Months ___/ No   Nursing? Yes / No   Taking Birth Control? Yes / No

Physicians Name ____ Phone # ______-_____-_______

Last Visit ________   Last Physical ________   Please List ALL Medicines you are taking:

____

Are you Allergic or had a Reaction to any Medicines or Treatment? If so What?

____

Have you ever had a reaction to any dental work, treatment or Anesthesia?

____

Do you have any concerns with your teeth or gums?____

Are you happy with your smile? ____

Do you have headaches or migraines? ____

Any Pain in the jaw or teeth? ____

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication. I also understand that any treatment done in the office in my financial responsibility.

Patient/Guardian Signature: ____________________________   Date : _________________________