all smiles.

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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
Allergic reaction to		
Aspirin, ibuprofen, acetaminophen		
Penicillin		
Erythromycin		
Tetracycline		
Codeine		
Local anesthetic		
Fluoride		
Metals (gold, stainless steel)		
Latex		
Any other medications		
Heart problems	YES	NO
Heart murmur	YES	NO
Rheumatic fever	YES	NO
Scarlet fever	YES	NO
High blood pressure	YES	NO
Low blood pressure	YES	NO
A stroke	YES	NO
Artificial prosthesis (i.e., heart valve or joints)	YES	NO
Anemia or other blood disorder	YES	NO
Prolonged bleeding due to a slight cut	YES	NO
Emphysema	YES	NO
Tuberculosis	YES	NO
Asthma	YES	NO
Sinus problems	YES	NO
Kidney disease	YES	NO
Liver disease	YES	NO
Jaundice	YES	NO
Thyroid or parathyroid disease	YES	NO
Hormone deficiency	YES	NO
High cholesterol	YES	NO
Diabetes	YES	NO
Stomach or duodenal ulcer	YES	NO
Digestive disorders	YES	NO
Arthritis	YES	NO
Glaucoma	YES	NO
Contact lenses	YES	NO
Head or neck injuries	YES	NO
Epilepsy or convulsions (seizures)	YES	NO
Viral infections and cold sores	YES	NO
Any lumps or swelling in the mouth	YES	NO
Hives, skin rash, hay fever	YES	NO
Venereal disease	YES	NO
Hepatitis - Type A B C D E	YES	NO
HIV / AIDS	YES	NO
Tumor, abnormal growth	YES	NO
Radiation therapy	YES	NO
Chemotherapy	YES	NO
Emotional problems	YES	NO
Psychiatric treatment	YES	NO
Antidepressant medication	YES	NO

ARE YOU:

Presently being treated for any illness	YES	NO
Aware of a change in your general health	YES	NO
Often exhausted or fatigued	YES	NO
Subject to frequent headaches	YES	NO
A heavy smoker (one pack or more per day)	YES	NO
Considered a touchy person	YES	NO
Often unhappy or depressed	YES	NO
Easily upset or irritated	YES	NO
Female - taking birth control pills	YES	NO
Female - pregnant	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 ______________________

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DOCTOR'S SIGNATURE ______________________

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