Medical History

1. Are you currently under medical treatment? . . . . . Yes No

If yes, for what?_____

Physician's Name _____ Phone_____

2. Are you currently taking any medication. . . . . Yes No

If yes, please list name and dosage_____

_____

3. Do you have any allergies? . . . . . Yes No

If yes, please list_____

4. Women: Are you pregnant or think you may be pregnant? Yes (_____ months) No

Are you nursing? Yes No

5. Are you required to pre-medicate before dental procedures/appointments? Yes No

6. Have you had joint replacement? . . . . . Yes No

If so, what joint_____

7. **Please circle all that apply :**

Acid Reflux	Epilepsy or Seizures	Neurological Disorders
A.I.D.S / H.I.V. Positive	Emphysema	Pacemaker
Anemia	Fainting or Dizzy Spells	Psychiatric Care
Artificial Heart Valve	Vertigo	Radiation Therapy
Arthritis/ Rheumatism	Glaucoma	Rheumatic Fever
Artificial Joints	Headaches	Shortness of Breath
Asthma	Heart Problems	Sinus Trouble
Back Problems	Heart Murmur	Skin Rash
Blood Disease	Hepatitis (type) ___	Stroke
Bruise Easily	Herpes	Swollen Neck Glands
Diabetes	High Blood Pressure	Thyroid Problems
Cancer	Kidney Disease	Tonsillitis
Cold Sores/Fever Blisters	Latex Sensitivity	Tumor/growth on head/neck
Chemotherapy	Liver Disease	Tuberculosis
Circulatory Problems	Low Blood Pressure	Venereal Disease
Congenital Heart Disease	Mitral Valve Prolapse	Other _____
Cortisone Treatments	Nervous/Anxious	

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all 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 dentist of any changes in my health or medication.

Signature: _____ Date: _____

Patient Name: _____