Medical History

Name: _____

Do you have a personal physician? ☐ Yes ☐ No
Physician's Name: _____
Physician's Phone: _____
Date of last visit: _____
Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you use tobacco in any form? ☐ Yes ☐ No
Have you had any metal rods, pins or implants placed? ☐ Yes ☐ No
Are you taking any medications? ☐ Yes ☐ No
Please list each one:

_____

_____

Have you ever had any surgical procedures? ☐ Yes ☐ No
Please list each one:

_____

Conditions (Yes or No)
☐ ☐ Abnormal Bleeding
☐ ☐ Alcohol Abuse
☐ ☐ Allergies
☐ ☐ Anemia
☐ ☐ Angina Pectoris(chest pain)
☐ ☐ Arthritis
☐ ☐ Artificial Heart Valve
☐ ☐ Asthma
☐ ☐ Blood Transfusion
☐ ☐ Cancer
☐ ☐ Chemotherapy
☐ ☐ Colitis
☐ ☐ Congenital Heart Defect
☐ ☐ Diabetes
☐ ☐ Difficulty Breathing
☐ ☐ Drug Abuse
☐ ☐ Emphysema
☐ ☐ Epilepsy
☐ ☐ Facial Surgery
☐ ☐ Fainting Spells

Conditions (Yes or No)
☐ ☐ Fever Blisters
☐ ☐ Frequent Headaches
☐ ☐ Glaucoma
☐ ☐ HIV+ AIDS
☐ ☐ Heart Attack
☐ ☐ Heart Murmur
☐ ☐ Heart Surgery
☐ ☐ Hemophilia
☐ ☐ Hepatitis A, B or C
☐ ☐ High Blood Pressure
☐ ☐ Joint Replacement
☐ ☐ Kidney Problems
☐ ☐ Liver Disease
☐ ☐ Low Blood Pressure
☐ ☐ Mitral Valve Prolapse
☐ ☐ Pace Maker
☐ ☐ Psychiatric Problems
☐ ☐ Radiation Therapy
☐ ☐ Rheumatic Fever

Conditions (Yes or No)
☐ ☐ Seizures
☐ ☐ Shingles
☐ ☐ Sickle Cell Disease
☐ ☐ Sinus Problems
☐ ☐ Stroke
☐ ☐ Thyroid Problems
☐ ☐ Tuberculosis
☐ ☐ Ulcers

Allergies (Yes or No)
☐ ☐ Aspirin
☐ ☐ Codeine
☐ ☐ Dental Anesthetics
☐ ☐ Erythromycin
☐ ☐ Jewelry
☐ ☐ Latex
☐ ☐ Metals
☐ ☐ Penicillin
☐ ☐ Tetracycline

If Female, Please Answer
Are you taking Birth Control Pills? YES☐ NO☐
Are you pregnant? YES☐ NO☐ If so, # of Weeks _____
Are you nursing? YES☐ NO☐

Nearest relative not living with you: _____

Relationship: _____Address:_____

Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I consent to the diagnostic procedures and treatment by the dentist and his staff as necessary for proper dental care.

_____ _____

Signature of Patient, Parent or Guardian **Date**

_____ _____

Please print name of Patient, Parent or Guardian **Relationship to Patient**