

## Medical History

Patient \_\_\_\_\_

Physician \_\_\_\_\_ Date Of Last Visit \_\_\_\_/\_\_\_\_/\_\_\_\_

Please list all medications you are currently taking with dosage:

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List all allergies:

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Are you pregnant?  Yes  No    Nursing?  Yes  No    Taking birth control pills?  Yes  No

Indicate which of the following you have had, or have at present? (Check all that apply).

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|--|---|--|--|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever           |
| <input type="checkbox"/> Allergies or Hives      | <input type="checkbox"/> Cold Sores           | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath     |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Sinus Problems          |
| <input type="checkbox"/> Anxiety Problmes        | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash               |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough up blood       | <input type="checkbox"/> Kidney Trouble        | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Latex Sensitivity     | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems        |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit           |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Tonsillitis             |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart problems       | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Venereal disease        |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever       |  |

Other: \_\_\_\_\_  
\_\_\_\_\_

Please describe any positive responses from the list above:

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Do you smoke?  Yes  No Describe \_\_\_\_\_

Do you use alcohol?  Yes  No Describe \_\_\_\_\_

Do you use recreational drugs?  Yes  No Describe \_\_\_\_\_

Have you had surgery or been hospitalized in the last 5 years?  Yes  No Describe \_\_\_\_\_

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Dentist's Signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

History Review \_\_\_\_\_ History Review \_\_\_\_\_ History Review \_\_\_\_\_ History Review \_\_\_\_\_