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Print: Last Name First Name

____
Date of Birth

Medical History

1. Are you having pain or discomfort at this time? ……………………………………………………………………….……...…YES….NO
2. Do you feel very nervous about having dental treatment…………………………………………………………………..........YES….NO
3. Have you ever had a bad experience in a dental office or during treatment?. ……………………………………….…..…....YES….NO
4. Have you ever been hospitalized?..YES….NO
5. Have you seen a medical doctor in the past two years………………………………………………………………………. .YES….NO
6. Have you taken any medicine or drugs in the past two years?... ……………………………......YES….NO
7. Are you allergic to (i.e. itching, rash, hives, swelling of hands, feet, eyes), had a reaction to or made sick by penicillin, aspirin, codeine or any medication?............................ ………...YES….NO
8. Have you ever had any excessive bleeding requiring special treatment?..YES….NO
9. Have you ever been treated with bisphosphonates (i.e. Fosamax, Boniva, Actonel, Zometa)?.. YES….NO
10. CIRCLE any of the following which you have had or have at present, or subject to

Heart Murmur/MVP	Emphysema	AIDS or HIV
Heart Disease or Attack	Cough	Hepatitis ___A___B __C
Angina Pectoris (Chest Pain)	Tuberculosis (TB)	Hepatitis (other)
High Blood Pressure	Asthma	Liver Disease
Low Blood Pressure	COPD	Blood Transfusion
Congenital Heart Disease	Hay Fever	Alcohol Abuse
Scarlet Fever	Sinus Trouble	Drug Addiction
Artificial Heart Valve	Allergies/Hives	Hemophilia
Heart Pacemaker/Defibrillator	Diabetes	Venereal Disease (VD)
Heart Surgery	Thyroid Disease	Cold Sores
Artificial Joint	Radiation Therapy	Herpes Virus
Anemia	Chemotherapy	Epilepsy/Seizures
Stroke or TIA	Arthritis	Fainting/Dizzy Spells
Kidney Trouble	Cortisone/Steroid Therapy	Anxiety/Emotional Disorder
Ulcers	Glaucoma	Psychiatric Treatment
Gastrointestinal Disease	Pain in Jaw Joints (TMJ)	Depression
Lung Disease	Neurological Disease	Sickle Cell Disease
Reaction to Local Anesthesia	Autoimmune Disease	Bruise easily
Reaction to General Anesthesia	Osteoporosis or Osteopenia	Other____________________

11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are tired?.. YES….NO
12. Do your ankles swell during the day? .... YES….NO
13. Do you use more than 2 pillows to sleep? …………………………………………..………………………………….... YES….NO
14. Have you lost or gained more than 10 pounds in the past year? ……………………………………………………………...YES….NO
15. Do you ever wake up from sleep short of breath? ....YES….NO
16. Are you on a special diet? If so, for what? .... YES….NO
17. Has a doctor ever said you have a cancer or tumor? .... YES….NO
18. Do you have any disease, condition, or problem not listed? .... YES….NO
19. WOMEN: Are you pregnant now? .... YES….NO
    Are you practicing birth control? .... YES….NO
    Do you anticipate becoming pregnant? .... YES….NO
20. Do you wear contact lenses? .... YES….NO
21. Are you taking any medication? List……………………………………………………………………………………..… YES….NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

__________ ____ ____
Date Signature or Patient, Parent or Guardian Witness

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Date	Additions-if none so indicate	Signature	Witness