MEDICAL HISTORY

PATIENT NAME:_____ DATE OF BIRTH:_____

PHYSICIAN'S NAME:_____ PHONE:_____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

1.	Do you consider yourself to be in good health?	YES	NO
2.	Are you now or have you been under a physician's care within the past year?	YES	NO
	If Yes, specify condition being treated_____		
3.	Do you take any medications, including birth control pills?	YES	NO
	Please specify name and purpose of medications:_____		
	_____		
	_____		
4.	Do you have or have you ever had any heart or blood problems?	YES	NO
5.	Have you ever been told that you have a heart murmur?	YES	NO
6.	Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint?	YES YES	NO. NO
7.	Do you have or have you ever had high blood pressure?	YES	NO
8.	Do you bleed or bruise easily?	YES	NO
9.	Have you ever been diagnosed as being HIV positive or having AIDS?	YES	NO
10.	Have you ever had hepatitis or liver disease?		
11.	Have you ever had: rheumatic fever_____; asthma_____; any blood disorder_____; diabetes_____; rheumatism_____; arthritis_____; tuberculosis_____; venereal disease_____; heart attack_____; kidney disease_____; immune system disorders_____; other disease_____? If so, specify:	YES	NO
12.	Have you ever had an unusual reaction or are you allergic to any of the following drugs: Penicillin_____; Aspirin_____; Acetominophen_____; Ibuprofen_____; Codeine_____; Barbiturates_____; Sulfa Drugs_____; Other	YES	NO
13.	Are you subject to fainting?	YES	NO
14.	Have you ever had any severe reaction to dental treatment or local anesthetics?	YES	NO
15.	Are you allergic to any local anesthetic?	YES	NO
16.	Do you have any other allergies? If Yes, please describe:_____	YES	NO
17.	Have you ever had a nervous breakdown or undergone psychiatric treatment?	YES	NO
18.	Have you ever received counseling for use of alcohol and/or prescription drugs?	YES	NO
19	Women: Are you pregnant?	YES	NO
20.	Are you now in pain?	YES	NO
21.	How long ago did you last see a dentist? _____		
22.	Who was your previous dentist?_____		
23.	Do you think that your teeth are affecting your general health in any way?	YES	NO
24.	Do you have or have you ever had bleeding or sensitive gums?	YES	NO
25.	Have you ever taken Phen-Fen or similar appetite suppressants?	YES	NO
	If Yes, have you seen your physician or cardiologist for a cardiac evaluation?	YES	NO
26.	Have you ever used or are you now using tobacco or alcohol?	YES	NO
27.	Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease The resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?	YES	NO

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature_____ Date_____

(Patient, legal guardian or authorized agent of patient)

(Rev. 8/00)