MEDICAL HISTORY

Patient Name: _____

1. Chief Complaint:_____
2. Are you presently under the care of a physician? …….. YES NO
3. Name and telephone number of physician. _____
_____
4. Do you feel very nervous about having dental treatment? ……..…… YES NO
5. Have you ever had a bad experience in the dental office? ……..……. YES NO
6. Do your gums bleed at any time? ……..… YES NO
7. Do you smoke or chew tobacco products? …… YES NO
8. How do you feel about getting and maintaining a healthy mouth? _____
_____
9. How do you feel about the appearance of your teeth? _____
_____
10. If you could change anything about your smile, what would you change? _____
_____
11. Are you allergic to or made sick by penicillin, aspirin, codeine, local anesthetic or any other medications or drugs? Y/N What: _____
12. Have you ever been advised to pre-medicate prior to any dental treatment? Y/N
13. If so, with what? _____
14. Circle any of the following which you have had or have at present: None

HIV Positive (AIDS)	Shortness of Breath	Hepatitis A or B or C
Artificial Heart Valve	Emphysema	Asthma
Artificial Joint	Liver Disease	Tuberculosis (TB)
Heart Related Concern – Type _____		Hay Fever/Sinusitis
Eating Disorder	Allergies or Hives	Blood Transfusion
Cortisone Medication	Drug \ Alcohol Addiction	Diabetes
Bruise Easily	Thyroid Disease	Venereal Disease
Angina Pectoris (chest pain)	Cancer - Type_____	Parkinson's
High Blood Pressure	Chemotherapy -Active Y/N	Epilepsy \ Seizures
Autoimmune Disease - Type _____		Fainting \ Dizzy Spells
Rheumatic Fever	Rheumatism/ Arthritis	Excessive Bleeding
Congenital Heart Lesions	Glaucoma	Psychiatric Treatment
Scarlet Fever	Pain in Jaw Joints	Sickle Cell Disease
Heart Pacemaker	Anemia	Heart Attack \ Stroke

15. Women: Are you pregnant? YES NO If yes, what month are you due? _____
16. List all medication you are taking at this time: _____

Signature Responsible Party **Date**

UPDATE Patient Signature	**DATE**	**UPDATE** Patient Signature	**DATE**