MEDICAL HISTORY

Patient Name: ____________________________ DOB: ___________________

Physician Name:_______________________________

Do you have or have you had any of the following diseases or problems? (Circle all that apply)

Angina	Cardiac Pacemaker	Liver Disease
Artificial Heart Valves	Diabetes	Psychiatric Problems
Aids/HIV	Epilepsy	Rheumatic Fever
Arthritis	Fainting Spells	Sleep Apnea
Asthma	Hepatitis	Sinus Trouble
Anemia	Hemophilia	Stroke
Blood Pressure High	Heart Trouble	Thyroid
Blood Pressure Low	Heart Murmur	Tuberculosis
Bone/Joint Replacement	Hives	Venereal Disease
Cancer	Immunosuppressive Disorders	

WOMEN: Are you Pregnant___________Due Date________________Nursing__________

Are you allergic or have you reacted adversely to: (circle all that apply)

Aspirin	Iodinie	Penicillin
Barbituates,Sedatives or Sleeping Pills	LATEX Products	Other Antibiotics
Codeine or Other Narcotics	Local Anesthetics	Sulfa Drugs

Other____

____

Are you presently taking any of the following: (circle all that apply)

Antibiotics or Sulfa Drugs	Aspirin	Anticoagulants (Blood Thinners)
Insulin, Tolbutamide (Orinase) Or Similar Drug	Medicine for High Blood Pressure	Nitroglycerin
	Tranquilizers	Antihistamines
Cortisone (Steroids)	Oral Contraceptive or Other Hormonal Therapy	Fluoride

Other____

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Do you have any disease, condition, or problem not listed that you think I should know about?________________

If so, explain____

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Have you had any serious trouble associated with any previous dental treatment?__________________________

If so, explain____

Have you ever been told you need to be pre-medicated before dental treatment?___________________________

I certify that I have read and understand the above. I acknowledge that my questions, if any about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_________________________________ ____________ ______________________________

Signature of Patient or Guardian if Minor   Date   Signature of Dentist