PATIENT'S NAME ____

Last | First | Initial | Date of Birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

COMMENTS

List Medications

#	Question		
1	Physician's Name ____________		
	Phone No. ____________		
2	Are you under a physician's care?	YES	NO
	If yes, what for & how long? ____________		
3	When was your last physical exam? ____________		
4	Are you taking any medications or substances?	YES	NO
5	Do you routinely take health related substances?	YES	NO
6	Have you ever taken Phen Phen?	YES	NO
7	Are you allergic to any medications? (If yes, please list)	YES	NO
8	Do you have any allergies other than medications?	YES	NO
9	Do you have any problems with anesthetics?	YES	NO
10	Are you sensitive to metals or latex?	YES	NO
11	Are you pregnant or suspect you may be?	YES	NO
12	Do you use birth control medications?	YES	NO
13	Have you ever been treated for or told you might have heart disease?	YES	NO
14	Do you have a pacemaker or an artificial heart valve?	YES	NO
15	Have you ever had rheumatic fever?	YES	NO
16	Are you aware of any heart murmurs?	YES	NO
17	Do you have blood pressure problems? High or Low	YES	NO
18	Have you ever had a serious illness or major surgery?	YES	NO
	Please Explain ____________		
19	Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?	YES	NO
20	Do you have inflammatory disease, such as arthritis or rheumatism?	YES	NO
21	Do you have any artificial joints/prosthesis?	YES	NO
22	Do you have any blood disorders, such as anemia, leukemia,etc.?	YES	NO
23	Have you ever bled excessively after being cut or injured?	YES	NO
24	Do you have any stomach problems?	YES	NO
25	Do you have any kidney problems?	YES	NO
26	Do you have any liver problems?	YES	NO
27	Are you diabetic?	YES	NO
28	Do you have asthma?	YES	NO
29	Do you have epilepsy or seizure disorders?	YES	NO
30	Do you or have you ever had a venereal disease? (If yes, Please list type)	YES	NO
31	Have you tested HIV positive?	YES	NO
32	Do you have AIDS?	YES	NO
33	Have you had or do you test positive for hepatitis?	YES	NO
34	Do you or have you ever had T.B.?	YES	NO
35	Do you smoke, chew, use snuff or any other form of tobacco?	YES	NO
36	Do you consume alcoholic beverages?	YES	NO
37	Do you habitually use controlled substances?	YES	NO
38	Have you had psychiatric treatment?	YES	NO
39	Do you have any disease, condition or problem not listed?	YES	NO
40	Is there anything else we should know about your health?	YES	NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE ____________________ DATE __________

DENTIST'S SIGNATURE ____________________ DATE __________

MEDICAL HISTORY