MEDICAL HISTORY

Physician's Name _____ Phone # _____
Most recent physical examination _____ Purpose _____
Estimate of your general health? (Circle One) Poor Fair Good

Allergic reaction to...

Ibuprofen?	Y	N
Acetaminophen?	Y	N
Aspirin?	Y	N
Penicillin?	Y	N
Erythromycin?	Y	N
Tetracycline?	Y	N
Codeine?	Y	N
Metals?	Y	N
Latex?	Y	N
Other? _____ _____	Y	N

Have you had the following?

Hospitalization for illness/injury?	Y	N
Heart problems?	Y	N
Heart murmur?	Y	N
Rheumatic fever?	Y	N
Scarlet fever?	Y	N
High blood pressure?	Y	N
Low blood pressure?	Y	N
Stroke? When? _____	Y	N
Artificial prosthesis (i.e. heart valve)?	Y	N
Anemia or other blood disorder?	Y	N
Prolonged bleeding due to slight cut?	Y	N
Emphysema?	Y	N
Asthma?	Y	N
Sinus problems?	Y	N
Kidney disease?	Y	N
Liver disease?	Y	N
Jaundice?	Y	N
Thyroid or Parathyroid disease?	Y	N
Hormone Deficiency?	Y	N
High cholesterol?	Y	N

Diabetes?	Y	N
Stomach or duodenal ulcer?	Y	N
Digestive disorders?	Y	N
Arthritis?	Y	N
Glaucoma?	Y	N
Contact lenses?	Y	N
Head or neck injury?	Y	N
Epilepsy, convulsions, seizures?	Y	N
Viral infections and cold sores?	Y	N
Any lumps or swelling in mouth?	Y	N
Hives, skin rash, hay fever?	Y	N
Venereal disease?	Y	N
Hepatitis (type _____)?	Y	N
Tumor, abnormal growth?	Y	N
Cancer (type_____)? When? ____	Y	N
Chemotherapy?	Y	N
Radiation therapy?	Y	N
Emotional problems?	Y	N
Psychiatric treatment?	Y	N
Antidepressant medication?	Y	N
Alcohol/ drug dependency?	Y	N

Are you currently...

Being treated for any illness?	Y	N
Aware of a change in your health?	Y	N
Often exhausted or fatigued?	Y	N
Subject to frequent headaches?	Y	N
Heavy smoker (1+ packs a day)?	Y	N
Often unhappy or depressed?	Y	N
Easily upset or irritated?	Y	N
(Female) Taking birth control?	Y	N
(Female) Pregnant?	Y	N
(Male) Prostate disorder?	Y	N

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment _____

List any medications, herbal supplements, and/or vitamins you have taken within the last two years

_____

PLEASE ADVISE US OF ANY FUTURE CHANGES IN YOUR MEDICAL HISTORY OR MEDICATIONS

Patients Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____