MEDICAL HISTORY

1. Are you currently under the care of a medical doctor: Yes No

Condition being treated: _____

Physician's name _____ Phone ( ) _____

2. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" for each:

Tire Easily,Weakness: Yes No	*Glaucoma:* Yes No	*A.I.D.S:* Yes No
Heart (surgery, disease, attack): Yes No	*Visual changes:* Yes No	*H.I.V. Positive:* Yes No
Chest Pain: Yes No	*Emphysema:* Yes No	*Cold Sores/Blisters:* Yes No
Congenital Heart Disease: Yes No	*Chronic Cough:* Yes No	*Blood Transfusion:* Yes No
Heart Murmur: Yes No	*Tuberculosis:* Yes No	*Anemia:* Yes No
High Blood Pressure: Yes No	*Asthma:* Yes No	*Hemophilia:* Yes No
Shortness of breath: Yes No	*Hay Fever:* Yes No	*Bruise Easily:* Yes No
Artificial Heart Valve: Yes No	*Sputum production (phlegm):* Yes No	*Liver Disease:* Yes No
Heart Pacemaker: Yes No	*Cough up blood sputum:* Yes No	*Yellow Jaundice:* Yes No
Osteoprosis/Osteopenia: Yes No	*Difficulty breathing while lying down:* Yes No	*Neurological Disorder:* Yes No
Arthritis/Rheumatism: Yes No	*Allergies or Hives:* Yes No	*Epilepsy/Seizures:* Yes No
Numbness/Tingling: Yes No	*Sinus Trouble:* Yes No	*Fainting/Dizzy Spells:* Yes No
Swollen Ankles: Yes No	*Frequent nosebleeds:* Yes No	*Nervous/Anxious:* Yes No
Stroke: Yes No	*Cancer:* Yes No	*Psychiatric Care:* Yes No
Diet (specialized/restricted): Yes No	*Radiation Therapy:* Yes No	*Loss of hearing:* Yes No
Artificial Joints (hip/knee): Yes No	*Chemotherapy:* Yes No	*Ringing in Ears:* Yes No
Kidney Trouble: Yes No	*Tumors:* Yes No	*Skin rash/hives:* Yes No
Ulcers: Yes No	*Hepatitis A or B:* Yes No	
Diabetes: Yes No	*Night sweats:* Yes No	
Thyroid Problems: Yes No	*Veneral Disease:* Yes No	

3. Any marked weight change Yes No

4. Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please list _____

_____

5. Women, are you: Pregnant? Yes ___ Months No Nursing? Yes No Taking birth control pills? Yes No

6. Are you ALLERGIC or have you ever experienced any reaction to the following?

Local anesthetics (e.g. Novocaine): Yes No	*Aspirin or Codeine:* Yes No	*Other allergies:* Yes No
Barbiturates/sedatives/sleeping pills: Yes No	*Sulfa drugs:* Yes No	
Penicillin/other antibiotics: Yes No	*Latex:* Yes No	

7. Are you taking any of the following?

Antibiotic/sulfa drugs: Yes No	*Antihistamines/allergy drugs/cold remedies:* Yes No	*Recreational drugs:* Yes No
Blood thinners: Yes No	*Bisphosphonates (i.e. fosamax):* Yes No	*Digitalis/other heart medication:* Yes No
Blood pressure medication: Yes No	*Herbal/Homeopathic:* Yes No	*Nitroglycerin:* Yes No
Thyroid medicine: Yes No	*Tranquilizers:* Yes No	*Aspirin:* Yes No
Cortisone/steroids: Yes No	*Insulin/other diabetes drugs:* Yes No	*Other Medication:* Yes No

If yes, to any of the above, list name of the medication and dosage below:

1. _____

2. _____

3. _____

4. _____

Comments: _____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient, Patient or Guardian_____ Date ____/____/____