Medical History

1. Are you in good health? ..... [] Yes [] No

2. Has there been a change in your general health within the past year? ..... [] Yes [] No

3. Do you require pre-medication prior to dental procedures? (ie: hip and/or knee replacements, etc.) ..... [] Yes [] No

4. Are you under the care a physician? ..... [] Yes [] No

5. If so, what condition is being treated? _____

6. Date of your last visit to your physician _____ Nature of visit _____

7. Your physician's name _____ Phone #_____

   Address of physician _____

8. Have you ever been hospitalized or had a serious operation or illness within the last five years? ..... [] Yes [] No

   If so, for what? _____

9. Do you have, or have you had, any of the following diseases or problems? **Please check:**

[] Heart Failure	[] Kidney Trouble	[] Sinus Trouble	[] Nervousness/Anxiety
[] Emphysema	[] AIDS/HIV	[] Rheumatism	[] Chemotherapy (e.g. Cancer, Leukemia)
[] Diabetes	[] Ulcers	[] Allergies or Hives	
[] Lupus	[] Cold Sores	[] Cortisone Medicine	[] Radiation Treatment (head, neck)
[] Thyroid disease	[] Bruise Easily	[] Scarlet Fever	[] Heart Disease or Attack
[] Angina Pectoris	[] STD or VD (e.g.	[] Artificial Joint	[] Mitral Valve Prolapse
[] Arthritis	Syphilis, Gonorrhea)"	[] Glaucoma	[] Psychiatric Treatment
[] Tuberculosis (TB)	[] Hepatitis A, B, or C	[] Anemia	[] Fainting or Dizzy Spells
[] High Blood Pressure	[] Sickle Cell Disease	[] Pain in Jaw Joints	[] Artificial Heart Valve
[] Asthma	[] Blood Transfusion	[] Heart Pacemaker	[] Epilepsy or Seizures
[] Heart Murmur	[] Liver Disease	[] Stroke	[] Bleeding Disorder
[] Hay Fever	[] Yellow Jaundice	[] Heart Surgery	[] Rheumatic Fever
[] Jaundice	[] Respiratory Problems	[] Phen Fen (1 month +)	[] Stomach Problems

[] OTHER: _____

10. Are you taking any drugs, medicines, or vitamin supplements? ..... [] Yes [] No

    If so, please list_____

11. Are you allergic, or have you reacted adversely, to any drugs or medicine? ..... [] Yes [] No

    If so, which drugs? _____

    [] Aspirin [] Erythromycin [] Codeine [] Local Anesthetic [] Epinephrine [] Latex
    [] Penicillin [] Nitrous Oxide [] Novocain or Xylocaine [] Other: _____

12. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest? ..... [] Yes [] No

13. Do your ankles swell during the day? ..... [] Yes [] No

14. Do you have a disease condition, or problem not listed above that you think I should know? ..... [] Yes [] No

15. For women only: Are you pregnant? [] Yes [] No If so, what month? _____ Breast-feeding? [] Yes [] No
    Are you taking birth control pills? [] Yes [] No

Patient signature: _____Dr./ Team signature_____

Update signature: _____ Date: _____