PATIENT NAME:____ **DATE:**______________________

Patient Medical History

Directions: Please circle applicable answer. Your answers are for our records only and will be considered confidential.

1. a. Are you in good health? Yes No
   b. Has there been any change in your health in the past year? Yes No

2. Approximate date of your last physical examination____
   Approximate date of your last dental exam____

3. Is a physician currently treating you? If so, why?____ Yes No
4. Have you been hospitalized or had a serious illness within the last five (5) years? Yes No
   If so, what was the problem____
5. The name and address of your physician:____

6. **Do you take any pills, drugs, or medicines?** Yes No
   If so, what?____
7. **Are there any medications that you are allergic to or cannot take, such as aspirin, codeine, penicillin, morphine,** valium, **barbiturates**? Which Ones?____
8. Have you experienced an unusual reaction to local anesthetic (e.g. novocaine)? Yes No
9. Are you allergic to latex? Yes No

10. Have you ever had any of the following? *Please check if applicable.*

___AIDS	___Blood Disease	___X-ray Treatments	___HIV Positive
___Anemia	___Excessive Bleeding	___Chemotherapy	___Yellow Jaundice
___Angina/Chest Pain	___Hemophilia(Bleeding Problem)	___Gastric Reflux	___Kidney Problems
___Cancer	___Leukemia	___Ulcers	___Renal Dialysis
___Congenital Heart Disorder	___Lung Disease	___Diabetes	___Thyroid Disease
___Heart Trouble/Disease	___Breathing Problems	___Excessive Thirst	___Parathyroid Disease
___Heart Murmur	___Sinus Trouble	___Hypoglycemia	___Rheumatism
___Heart Pace Maker	___Asthma	___Liver Disease	___Pain in Jaw Joints
___Artificial Heart Valve	___Emphysema	___Hepatitis A (Infectious)	___Cold Sores
___Rheumatic Fever	___Tuberculosis	___Hepatitis B or C	___Fever Blisters
___High /Low Blood Pressure	___Recent Weight Loss	___Drug Addiction	___Herpes
___Stroke	___Convulsions/Seizures	___Glaucoma	___Tumors or Growths

Have you ever had any serious disease/medical condition not mentioned above?____ Discuss__________________________
____

11. Do you have an artificial heart valve, hip prosthesis or other implant? Yes No

12. Cardiovascular:
    a. Do you have chest pain on mild exertion? Yes No
    b. Are you short of breath after mild exertion? Yes No
    c. Do your ankles swell? Yes No
    d. Do you get short of breath when you lie down or do you require extra pillows when you sleep? Yes No

13. a. Does your mouth frequently become dry? Yes No

    b. Is there history of diabetes in your family? Yes No
    c. Do you have to urinate frequently? Yes No

14. Do you have a persistent cough or cough up blood? Yes No
15. Are you wearing contact lenses? Yes No

16. a. Do you smoke? Yes No
    b. Do you chew smokeless tobacco? Yes No
17. Do you have a tendency to faint? Yes No

18. Does it make you anxious/nervous to visit the dentist? Yes No
19. Have you had any problems associated with previous dental treatment? Yes No
20. Do you think that your teeth are affecting your general health in any way? Yes No

21. **If female**, please circle if you are: 1) pregnant 2) nursing 3) taking birth control pills

Chief Dental complaint: ____
____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above 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:____

ASA__

Medical Updates

I have read my MEDICAL HISTORY dated______________and confirm that it adequately states past and present conditions.

Date	Exceptions	Patient's Initials	BP	Reviewed by
______	______________________________None___	_____________	______	Dr.__________________________
______	______________________________None___	_____________	______	Dr.__________________________
______	______________________________None___	_____________	______	Dr.__________________________
______	______________________________None___	_____________	______	Dr.__________________________