MEDICAL/DENTAL HISTORY

Name _____ Date _____
Physician's Name _____ Physician's Phone# _____
Physician's Address_____ Date of Last Visit_____

Are you presently under a physician's care? [ ]Yes [ ] No
Please list any prescription/over the counter drugs which you are taking:_____
_____

Have you ever had any of the following:

Heart Attack/Stroke	Y N	Cancer/Chemotherapy/		Epilepsy/Seizures/Fainting Spells	Y N
Heart Murmur	Y N	Radiation Treatment	Y N	Diabetes/Tuberculosis (TB)	Y N
Heart Surgery/Pacemaker	Y N	Kidney/Liver Problems	Y N	Psychiatric/Nervous Problems	Y N
Mitral Valve Prolapse	Y N	Artificial Bones/Joints	Y N	Severe/Frequent Headaches	Y N
High/Low Blood Pressure	Y N	Sinus Problems	Y N	Hemophilia/Abnormal Bleeding	Y N
Congenital Heart Defect	Y N	Fever Blisters/Cold Sores	Y N	Anemia/Leukemia/Sickle Cell	Y N
Rheumatic Feve	Y N	Drug/Alcohol Abuse	Y N	Ulcers/Colitis/Stomach Problems	Y N
HIV+/AIDS	Y N	Emphysema/Asthma	Y N	Hepatitis/Jaundice/Cirrhosis	Y N
Tobacco Use	Y N	Glaucoma/Arthritis	Y N	Bad Reaction to Anesthetics	Y N
Venereal Disease	Y N	Blood Transfusion	Y N	Hospitalized for Any Reason	Y N
Latex/Metal Allergies	Y N	Valvular Replacements	Y N		

Have you ever been a member of the following groups? (Optional)
[ ] IV Drug User [ ] Homosexual/Bisexual Male [ ] Dialysis Patient [ ] Blood Bank Worker

Please list any serious medical conditions you have ever had:_____
Please list any medicine/drugs you are allergic to:_____

FOR WOMEN: Are you taking birth control pills? [ ] Yes [ ] No
Are you pregnant? [ ] Yes [ ] No

DENTAL HISTORY: Are you currently in pain? [ ] Yes [ ] No
Why have you come to the dentist today?_____
Have you ever had a serious/difficult problem associated with previous dental work? [ ] Yes [ ] No
How many times a day do you brush?_____ How many times a week do you floss?_____

I understand the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____ _____
Signature Date

Notes:

_____ _____
Dr.'s Signature Date