MEDICAL HISTORY

PATIENT NAME:_____ **DATE OF BIRTH:**_____

PHYSICIAN'S NAME:_____ **PHONE:**_____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

1.	**Do you consider yourself to be in good health?**	**YES**	**NO**
2.	**Are you now or have you been under a physician's care within the past year?**	**YES**	**NO**
	If Yes, specify condition being treated_____		
3.	**Do you take any medications, including birth control pills?**	**YES**	**NO**
	Please specify name and purpose of medications:_____		
	_____		
	_____		
4.	**Do you have or have you ever had any heart or blood problems?**	**YES**	**NO**
5.	**Have you ever been told that you have a heart murmur?**	**YES**	**NO**
6.	**Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint?**	**YES**	**NO**
7.	**Do you have or have you ever had high blood pressure?**	**YES**	**NO**
8.	**Do you bleed or bruise easily?**	**YES**	**NO**
9.	**Have you ever been diagnosed as being HIV positive or having AIDS?**	**YES**	**NO**
10.	**Have you ever had hepatitis or liver disease?**		
11.	**Have you ever had: rheumatic fever_____; asthma_____; any blood disorder_____; diabetes_____; rheumatism_____; arthritis_____; tuberculosis_____; venereal disease____; heart attack_____; kidney disease_____; immune system disorders_____; other disease_____? If so, specify:**	**YES**	**NO**
12.	**Have you ever had an unusual reaction or are you allergic to any of the following drugs: Penicillin_____; Aspirin_____; Acetominophen_____; Ibuprofen_____; Codeine_____; Barbiturates_____; Sulfa Drugs_____; Other**	**YES**	**NO**
13.	**Are you subject to fainting?**	**YES**	**NO**
14.	**Have you ever had any severe reaction to dental treatment or local anesthetics?**	**YES**	**NO**
15.	**Are you allergic to any local anesthetic?**	**YES**	**NO**
16.	**Do you have any other allergies? If Yes, please describe:**_____	**YES**	**NO**
17.	**Have you ever had a nervous breakdown or undergone psychiatric treatment?**	**YES**	**NO**
18.	**Have you ever received counseling for use of alcohol and/or prescription drugs?**	**YES**	**NO**
19	**Women: Are you pregnant?**	**YES**	**NO**
20.	**Are you now in pain?**	**YES**	**NO**
21.	**How long ago did you last see a dentist?** _____		
22.	**Who was your previous dentist?**_____		
23.	**Do you think that your teeth are affecting your general health in any way?**	**YES**	**NO**
24.	**Do you have or have you ever had bleeding or sensitive gums?**	**YES**	**NO**
25.	**Have you ever taken Phen-Fen or similar appetite suppressants?**	**YES**	**NO**
	If Yes, have you seen your physician or cardiologist for a cardiac evaluation?	**YES**	**NO**
26.	**Have you ever used or are you now using tobacco or alcohol?**	**YES**	**NO**
27.	**Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease The resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?**	**YES**	**NO**

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature_____ **Date**_____

(Patient, legal guardian or authorized agent of patient)