

Medical History **Today's Date** _____

Patient Name: _____ Male ___ Female ___ Date of Birth _____

Have you ever had a major operation? _____ Date: _____ Describe: _____

Have you ever had a head or neck injury? _____ Date: _____ Describe: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Please list names and phone numbers of the physicians who are currently providing you care:

Are you allergic to any of the following?: (Put an "x" in the box if you are allergic)

Aspirin	<input type="checkbox"/>	Acrylic	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	Other:	<input type="checkbox"/>
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Do you have/or have you ever been diagnosed with any of the following (check those that apply):

Artificial Limb	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Recent Transfusion	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>
Sickle Cell	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>

To the best of my knowledge, all of the proceeding answers are correct. If I have any changes in my health status or if my medicines change, I shall

PLEASE CIRCLE YES OR NO if this applies to you:			Are you on any type of restricted diet?	NO	YES
Have you ever had any serious illness not checked above? List:	NO	YES	Do you take herbal supplements (vitamins)?	NO	YES
Do you drink grapefruit juice on a regular basis?	NO	YES	Do you have sensitivity to tetracycline?	NO	YES
Do you take antacids (Tums, Rolaids) on a regular basis?	NO	YES	Are you currently taking antibiotics (within the last 6 wks)?	NO	YES
Are you aware of clenching or grinding?	NO	YES	Have you had periodontal (gum) treatment?	NO	YES
Do you take Tagamet?	NO	YES	Do you have an immunosuppressive disease including AIDS?	NO	YES
Are you a smoker?	NO	YES	Do you have a history of TMJ issues (clicks or pops in jaw)?	NO	YES

For Women Only

Are you pregnant?	YES	NO
Trying to get pregnant?	YES	NO
Are you nursing?	YES	NO
Using contraceptive?	YES	NO

inform the dentist and/or staff at the next appointment without fail. I hereby authorize the dental office to administer such medication and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right of the dentist to release dental/medical histories and other information about my dental treatment to third party payors and/or other health care professionals.

Signature of Patient/Guardian _____ Date ____/____/_____
 Signature of Doctor (I have reviewed the above patient's medical history) _____ Date ____/____/_____