

MEDICAL HISTORY FOR _____

PATIENT# _____

Are you having pain or discomfort at this time?.....YES NO
 Do you feel nervous about having dental treatment?.....YES NO
 Have you ever had a bad experience in a dental office?.....YES NO
 Have you been a patient in the hospital during the past two
 years?.....YES NO
 Have you taken any medicine or drugs during the past two
 years?.....YES NO
 Are you allergic to penicillin, antibiotics, aspirin, or
 any drugs or medications? YES NO
 Have you ever had any excessive bleeding requiring special
 treatment?.....YES NO

Circle any of the following which you have had or have at present:

- | | |
|---|--|
| 1-Heart Disease or Attack | 22-Sickle Cell Disease |
| 2-Angina Pectoris | 23-Emphysema |
| 3-High Blood Pressure | 24-Cancer or Tumor |
| 4-Heart Murmur | 25-Tuberculosis (TB) |
| 5-Rheumatic Fever | 26-Asthma |
| 6-Congenital Heart Lesions | 27-Hay Fever |
| 7-Scarlet Fever | 28-Sinus Trouble |
| 8-Artificial Heart Valve | 29-Allergies or Hives |
| 9-Prolapsed Mitral Valve | 30-Diabetes |
| 10-Heart Surgery or Pacemaker | 31-Thyroid Disease |
| 11-Artificial Joint | 32-Chemotherapy or
Radiation for Cancer |
| 12-Anemia | 33-Arthritis |
| 13-Stroke | 34-Cortisone Medicine |
| 14-Kidney Trouble | 35-Glaucoma |
| 15-Ulcers | 36-Pain in Jaw Joints(TMJ) |
| 16-HIV Positive/AIDS | 37-Hepatitis A, B, or C |
| 17-Liver Disease or Yellow Jaundice | 38-Hemophilia |
| 18-Drug Addiction | 39-Epilepsy or Dizzy Spell |
| 19-Sexually Transmitted Disease (STD'S) | 40-Psychiatric Treatment |
| 20-Genital Herpes | 41-Bruise Easily |
| 21-Nervousness | |

Do you have any condition or health problem not listed?.....YES NO
 If yes, please explain: _____

WOMEN: Are you pregnant now?.....YES NO
 Are you taking oral contraceptives?.....YES NO
 Do you anticipate becoming pregnant?.....YES NO

CURRENT MEDICATIONS

CONDITION

CURRENT MEDICATIONS	CONDITION

TO THE BEST OF MY KNOWLEDGE, ALL OF THE ABOVE ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGES IN MY HEALTH, OR MEDICATIONS, I WILL INFORM THE OFFICE AT MY NEXT APPOINTMENT.

DATE

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

STAFF/DR SIGN