MEDICAL HISTORY

Name:_____ Circle

1. Are you having pain or discomfort at this time?.....YES NO
2. Do you feel very nervous about having dental treatment?.....YES NO
3. Have you ever had a bad experience in the dental office?.....YES NO
4. Have you ever experienced and unusual reaction to a dental anesthetic?.....YES NO
5. Have you ever been a patient in the hospital during the past two years?.....YES NO
6. Have you been under the care of a medical doctor during the past two years?..... YES NO
7. Have you ever had any excessive bleeding requiring special treatment? …..... YES NO
8. Circle any of the following which you have had or have at present:

Anemia	Thyroid Disease	Blood Transfusion
Stroke	X-ray or Cobalt Treatment	Drug Addiction
Kidney Trouble	Chemotherapy(cancer/leukemia)	Hemophilia
High Blood Pressure	Ulcers	Arthritis
Venereal disease	Glaucoma	Rheumatism
Cold Sores	Emphysema	Cortisone Medicine
Genital Herpes	Rheumatic Fever	Cough
Pain in Joints	Epilepsy or Seizures	Tuberculosis (TB)
Alcoholism	Fainting or Dizzy Spells	Scarlet Fever
Asthma	AID/ARC	Nervousness
Hay Fever	Hepatitis	Psychiatric Treatment
Sinus Trouble	Liver Disease	Sickle Cell Disease
Heart Surgery	Allergies or Hives	Yellow Jaundice
Bruise Easily	Diabetes	Latex Allergy

9. Are you on a special diet?.....YES NO
10. Do you smoke?____ Packs per day…….....YES NO
11. Do you use smokeless tobacco?.....YES NO
12. Has your medical doctor ever said you have a cancer or tumor?.....YES NO
13. Are you being treated for a heart condition?.....YES NO
    Please list:
    Heart doctor_____
    Heart condition_____
    Heart Medications_____
14. Do you have an artificial joint hip, knee, etc. ?
    Orthopedic surgeon_____
    Joint medications _____
15. Have you ever been treated for osteoporosis?.....YES NO
    Medications taken_____
16. Do you have any disease, condition or problem not listed?.....YES NO
17. Do you wish to talk to the doctor privately about any problem…….....…… YES NO
18. WOMEN: Are you pregnant now?.....YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or medicines change, I will inform the dentist at the next appointment without fail. I consent to whatever dental procedures & anesthetics are necessary for treatment.

Date_____ Signature of patient, parent or guardian_____

LIST OF MEDICATIONS: