E-MAIL:

COMPLETE IN INK

DENTAL PATIENT MEDICAL HISTORY

NAME *(Last, First, Middle Initial)*	DATE OF BIRTH	AGE
ADDRESS ZIP	WORK PHONE	HOME PHONE

The answers to the following questions will assist the dentist in evaluating your general helath prior to providing your dental treatment.
PLEASE READ CAREFULLY AND ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE

1. WHAT IS YOUR IMPRESSION OF YOUR PRESENT HEALTH?

2. YEAR LAST MEDICAL PHYSICAL?

3. PLEASE DRAW A CIRCLE AROUND ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT.

Heart Disease or Condition	Rheumatic Fever	Asthma	Hepatitis	Venereal Disease (Syphilis,
Mitral Valve Prolapse	Stroke	Hay Fever	Thyroid Disease/Dysfunction	Gonorrhea)
Angina Pectoris	Hemophilia	Emphysema	Glaucoma	Drug Addiction
Frequent Chest Pains	Bruise Easily	Turberculosis (TB)	Epilepsy or Seizures	Psychiatric Treatment
High Blood Pressure	Prolonged or Unusual Bleeding	Diabetes	Fainting or Dizzy Spells	Cancer
Shortness of Breath	Anemia	Ulcers	AIDS or AIDS Related Complex	Radiation Therapy
Swollen Ankles	Blood Transfusion	Kidney Trouble	HIV Positive	Chemotherapy
Artificial Heart Valve	Sickle Cell Disease	Liver Disease	Cold Sores	Implants/Artificial Joints
Congenital Heart Disease	Arthritis	Jaundice (Other than at birth)	Genital Herpes	Unexplained Weight Loss
Heart Murmur				

Knee or joint replacement

CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS. *(IF IN DOUBT, CIRCLE YES.)*
(If YES, please give details.) **CONTINUE COMMENTS ON BACK IF NECESSARY**

4. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR? If yes, then list why.	**YES**	**NO**
5. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS? If yes, then list them.	**YES**	**NO**
6. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS?	**YES**	**NO**
7. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC?	**YES**	**NO**
8. HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS DURING OR FOLLOWING DENTAL TREATMENT?	**YES**	**NO**
9. DO YOU HAVE ANY ARTIFICIAL BODY PARTS?	**YES**	**NO**
10. DO YOU HAVE ANY DISEASES, CONDITIONS OR DISABILITIES NOT LISTED ABOVE?	**YES**	**NO**
11. HAVE YOU EVER BEEN TOLD THAT YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR?	**YES**	**NO**
12. DO YOU USE TOBACCO? *(If YES, please circle and give frequency)* **SMOKE:** Cigarettes Cigars Pipe **SMOKELESS:** Chewing Tobacco Snuff or "Dip" **FREQUENCY:** _____	**YES**	**NO**

13. WOMEN: ARE YOU PREGNANT? *(If YES, please circle trimester block)* **YES** | **NO**

TRIMESTER 1 2 3

SIGNATURE OF PATIENT (or legal guardian if patient is a minor)

X

DATE

X

DENTIST'S COMMENTS