PLEASE COMPLETE ALL INFORMATION

Patient Name ____ **Birth Date:** ____________________________

Medical History

Physician's Name: ______________________________ **Phone #:**________________________ **Date of Last Visit:** _____________

Have you had any serious illness? Yes If yes ____

Pregnant? Yes Due Date: ________________ Nursing: Yes Birth Control Pills? Yes

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other: ____

Are you taking any medications, pills, drugs, or controlled substances? Yes

Please List: ____

Do you use tobacco? Yes Are you on a special diet? yes Explain: ______________________________

Do you have any of the following (please check all that apply):

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Scarlet Fever
Artificial Joint	Excessive Bleeding	Hives or Rash	Shingles
Asthma	Fainting Spells/Dizziness	Hypoglycemia	Sickle Cell Disease
Blood Disease	Frequent Cough	Irregular Heartbeat	Sinus Trouble
Blood Transfusion	Frequent Diarrhea	Leukemia	Spina Bifida
Breathing Problems	Frequent Headaches	Liver Disease	Stomach/Intestinal Disease
Bruise Easily	Genital Herpes	Low Blood Pressure	Stroke
Cancer	Glaucoma	Lung Disease	Swelling of Limbs
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Thyroid Disease
Chest Pains	Heart Attack/Failure	Osteoporosis	Tonsillitis
Cold Sore/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tuberculosis
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Ulcers
Convulsions	Heart Trouble/Disease	Psychiatric Care	Venereal Disease
Anxiety/Depression		TMJ	Yellow Jaundice

Have you ever had any serious illnesses not listed? Yes Explain: ______________________________________

Have you ever had a serious head or neck injury? Yes Explain: ______________________________________

Have you ever been hospitalized or had a major operation? Yes Explain: ______________________________

Have you ever had an allergic reaction to Novocain, local or general anesthetics? Yes Explain: ______________________

Have you had trouble from previous dental care? Yes Explain: ______________________________________

Does your primary doctor recommend a pre-medication for dental visits? Yes Medication Prescribed: ____________________

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: ____ Date: ____________________

Reviewed By: ____ Date: ____________________

MEDICAL AND DENTAL HEALTH HISTORY