

PATIENT'S NAME _____
Last
First
Initial
Date of Birth

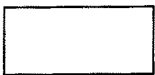
CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE 'DON'T KNOW' ON THE LINE AFTER THE QUESTION.

COMMENTS

1. Physician's Name _____
 Address _____
 2. Are you under a physician's care? YES NO
 Since When _____ Why? _____
 3. When was your last complete physical exam? _____
 4. Are you taking any medication or substances? YES NO
 (If yes, please list medications at the side of this form.)
 5. Are you allergic to any medications or substances? YES NO
 6. Do you have any other allergies? YES NO
 7. Do you have any problems with penicillin, antibiotics, anesthetics YES NO
 or any other medications?
 8. Are you sensitive to any metals or latex? YES NO
 9. Are you pregnant or suspect you may be? YES NO
 10. Do you use any birth control medications? YES NO
 11. Have you ever been treated for or been told you might have heart disease? YES NO
 12. Do you have a pacemaker or an artificial heart valve implant? YES NO
 13. Have you ever had rheumatic fever? YES NO
 14. Are you aware of any heart murmurs? YES NO
 15. Do you have high or low blood pressure? YES NO
 16. Have you ever had a serious illness or major surgery? YES NO
 If so, explain _____
 17. Have you ever had radiation treatment, chemo treatment for tumor, YES NO
 growth or other condition?
 18. Do you have inflammatory disease, such as arthritis or rheumatism? YES NO
 19. Do you any artificial joints/prosthesis? YES NO
 20. Do you have any blood disorders, such as anemia, leukemia, etc.? YES NO
 21. Have you ever bled excessively after being cut or injured? YES NO
 22. Do you have any stomach problems? YES NO
 23. Do you have any kidney problems? YES NO
 24. Do you have any liver problems? YES NO
 25. Are you diabetic? YES NO
 26. Do you have asthma? YES NO
 27. Do you have epilepsy or seizure disorders? YES NO
 28. Do you or have you had a sexually transmitted disease, HIV or hepatitis? YES NO
 29. Do you smoke? YES NO
 30. Have you had psychiatric treatment? YES NO
 31. Do you have any disease, condition, or problem not listed? If so, explain YES NO
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32. Is there anything else we should know about your health that we have YES NO
 not covered on this form? _____
 33. Would you like to speak to the doctor privately about any problem? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE
 PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____



MEDICAL HISTORY

