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.

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
    ____
    ____
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

COMMENTS

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

DENTIST'S SIGNATURE __________ *DATE* __________

MEDICAL HISTORY