MEDICAL HISTORY

(Please answer all questions and be as complete as possible)

Name of Medical Doctor: _____ Doctor's Phone: _____ Date of last physical exam: _____

Have you been in the hospital or treated by a physician in the past two years?	☐ No	☐ Yes, Explain:

Please check if you have OR have had any of the following:

☐ History of Tobacco Use	☐ Congenital Heart Lesions	☐ Tuberculosis	☐ Back Problems
☐ Heart Valve Replacement	☐ Heart Disease	☐ Diabetes	☐ Excessive Thirst
☐ Kidney or Liver Problems	☐ Heart Murmur	☐ AIDS/HIV	☐ Sinus Infection
☐ Bisphosphonate Use (i.e. Fosamax)	☐ Heart Bypass	☐ Epilepsy	☐ Headaches
☐ Blood Pressure (High or Low)	☐ Heart Pacemaker	☐ Glaucoma	☐ Anemia
☐ Prolonged Bleeding	☐ Radiation Therapy	☐ Asthma	☐ Ulcers
☐ Thyroid Problems	☐ Artificial Joints	☐ Hayfever	☐ Fainting
☐ Tumor or Malignancy	☐ Arthritis	☐ Hepatitis	☐ Herpes I or II
☐ Venereal Disease	☐ Stroke	☐ Other:	

Please answer the following questions:

Are you allergic to any medications?	☐ No	☐ Yes, List:
Are you allergic to or sensitive to latex?	☐ No	☐ Yes, Explain:
Do you take antibiotics prior to dental treatment?	☐ No	☐ Yes, Explain
Females, are you pregnant or nursing?	☐ No	☐ Yes, Due Date:

Please list all medications you are currently taking (prescriptions and/or over-the-counter):

Medication Name	Reason for Use	Dosage

(To list additional medications please continue on page 3 or attach photocopy of med list)

DENTAL HISTORY

Name of previous dentist: _____ Phone #: _____

Do you clench or grind your teeth?	☐ No	☐ Yes, Explain:
Do you have any dental pain/concerns?	☐ No	☐ Yes, Explain:

Patient/Guardian Signature: _____ Dr.'s Signature: _____

Date: _____ Date: _____