MEDICAL/DENTAL HISTORY

Patient Name (Print) _____ Date of Birth_____

Physician/MD_____ MD Phone#_____

Date of last physical _____ Current Physical Health is: Good____ Fair_____ Poor_____

Have you had any Hospitalizations or Surgeries? _____

Are you pregnant? Yes____ No_____ Do you smoke or use tobacco products? Yes____ No _____

HAVE YOU EVER PREMEDICATED FOR DENTAL TREATMENT BY TAKING ANTIBIOTICS? YES_____ No _____

List all allergies **including anesthetics**: _____

List **ALL** medications you are taking: _____

_____

_____

_____

Have you EVER been diagnosed/treated for any of the following? (Circle indicates YES)

ALCOHOL/DRUG ABUSE	CONGENITAL HEART	HEPATITIS C	PARKINSON DISEASE
ANEMIA	DIABETES	HERPES	RADIATION THERAPY
ARTHRITIS	DIALYSIS	HIGH BLOOD PRESSURE	RESPIRATORY ISSUES
ARTIFICIAL JOINTS/LIMBS	EMPHYSEMA	HIV/AIDS	RHEUMATIC FEVER
ARTIFICIAL VALVE	EPILEPSY/SEIZURES	KIDNEY DISEASE	SCARLET FEVER
ASTHMA/COPD	EXCESSIVE BLEEDING	IMMUNE SUPPRESSION	SHUNTS/STENTS
CANCER	FAINTING	LATEX ALLERGY	SINUS PROBLEMS
CHEMOTHERAPY	HEART ATTACK	LOW BLOOD PRESSURE	STROKE
CHEST PAINS	HEART MURMUR	NERVOUS/ANXIOUS	TUBERCULOSIS
CIRCULATORY ISSUES	HEART PROBLEMS	PACEMAKER	THYROID

Have you EVER HAD ANY OF THE FOLLOWING? (Circle indicates YES)

BAD BREATH	DRY MOUTH	MOUTH BREATHING	SNORING
BITE LIPS/CHEEKS	FOOD COLLECTION	ORTHO TREATMENT	SWELLING
BLEEDING GUMS	GRINDING TEETH	PAIN IN EAR AREA	SWOLLEN GUMS
BLISTERS ON LIPS/MOUTH	JAW PAIN/TENDERNESS	SLEEPING PROBLEMS	UNUSUAL LUMPS

Patient Signature **Date** Updated Updated Updated

_____ _____ _____ _____ _____

Dr. Signature

_____ _____ _____ _____ _____