MEDICAL HISTORY

Name of Physician:

Phone#: (   )

Please ✓ YES or NO to each question, if YES explain. If unsure of a question, please consult with dental professional

1. Are you currently being treated for any medical condition at present or within the past 2 years? ❑ Yes ❑ No
2. Have you been hospitalized in the past two years? ❑ Yes ❑ No
3. When was your last visit to a Physician?
4. Have you recently, or are you presently, taking any prescription or non-prescription drugs including herbal remedies? ❑ Yes ❑ No

   1. 2. 3.

   4. 5. 6.

5. Have you ever reacted adversely to any medications or injections? (**please circle**) e.g. Penicillin, or other antibiotics, aspirin, codeine, local anesthetic (freezing),, or any other medicine: ❑ Yes ❑ No
6. Had you ever been advised against taking any specific type of medication? ❑ Yes ❑ No
7. Do you have any of the following? (**please circle**) Latex or metal allergies, Hay fever, food allergies, skin rashes, hives, or any other allergic conditions? ❑ Yes ❑ No
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? ❑ Yes ❑ No
9. Is there a family history of diabetes, pancreatic cancer or other cancer, heart disease or periodontal disease? (please circle) ❑ Yes ❑ No
10. Do you bleed excessively from a cut or injury, or bruise easily? ❑ Yes ❑ No
11. Have you tested HIV positive? ❑ Yes ❑ No
12. Do you have frequent severe headaches, earaches, ear/throat infections? ❑ Yes ❑ No
13. Have you ever had any injury or surgery to your face or jaws? ❑ Yes ❑ No
14. Do you have hearing difficulties? ❑ Yes ❑ No
15. Do you smoke or use any other forms of tobacco? ❑ Yes ❑ No

    Are you wearing a transdermal nicotine patch? ❑ Yes ❑ No
16. Are you regularly using alcohol and/or recreational drugs? ❑ Yes ❑ No
17. **INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:**

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
A.I.D.S	❑ Yes	❑ No	Heart surgery	❑ Yes	❑ No	Lupus	❑ Yes	❑ No
Arthritis/rheumatism	❑ Yes	❑ No	Heart disease or attack	❑ Yes	❑ No	Malignant hyperthermia	❑ Yes	❑ No
Artificial joints (hip/knee)	❑ Yes	❑ No	Heart murmur	❑ Yes	❑ No	Mental Disorder	❑ Yes	❑ No
						Nervous disorder	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Pacemaker or artificial valve	❑ Yes	❑ No	Mitral valve prolapse	❑ Yes	❑ No
Blood disorders	❑ Yes	❑ No	Heart rhythm disorder	❑ Yes	❑ No	Organ transplant/ or medical implant	❑ Yes	❑ No
Cancer If yes, list type:	❑ Yes	❑ No	Hepatitis A B C (circle)	❑ Yes	❑ No	Psychiatric treatment	❑ Yes	❑ No
			Herpes	❑ Yes	❑ No	Radiation treatment/chemotherapy	❑ Yes	❑ No
Circulation problems	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Scarlet fever/rheumatic fever	❑ Yes	❑ No
			Low Blood Pressure	❑ Yes	❑ No	Sickle cell disease	❑ Yes	❑ No
Cortisone/Steroids	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No	Sinus trouble	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Hodgkin's disease	❑ Yes	❑ No	Stomach/ intestinal problems/ulcers	❑ Yes	❑ No
Emphysema/COPD	❑ Yes	❑ No	Hyper or Hypoglycemia	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Epilepsy or seizures	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	Thyroid disease	❑ Yes	❑ No
Fainting or dizzy spells	❑ Yes	❑ No	Kidney disease	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	Liver disease	❑ Yes	❑ No	Venereal disease	❑ Yes	❑ No
Head injury	❑ Yes	❑ No	Lung disease	❑ Yes	❑ No			

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18. Has the **CHILD PATIENT** recently had any of the following: (Indicate approximate date)

Condition	Yes	No	Condition	Yes	No
Measles	❑ Yes	❑ No			
Mumps	❑ Yes	❑ No	Strep throat	❑ Yes	❑ No
Chickenpox	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No

19. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? Please list if yes: ❑ Yes ❑ No