PATIENT'S NAME:_____

MEDICAL HISTORY

All information is completely confidential

1. Primary Physician's Name:_____ Phone:_____
   Address:_____
   Street Suite# City/State/Zip
2. Have you ever had any serious illness or operations? Yes No
   If yes, please describe:_____
3. Have you ever had a blood transfusion? Yes No If yes, when?_____
4. WOMEN: Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No
5. Do you have or have you ever had any of the following? (Please Circle)

A.I.D.S	Fainting	Pacemaker
Anemia	Headache	Psychiatric Care
Arthritis, Rheumatism	Heart Murmur	Radiation Treatment
Artificial Joints	Heart Problems	Respiratory Disease
Artificial Heart Valve	Describe_____	Rheumatic Fever
Asthma	Hemophilia	Scarlet Fever
Sickle Cell Disease	Hepatitis	Shortness of Breath
Blood Disease	High Blood Pressure	Skin Rash
Cancer/Tumor	HIV Positive	Stroke
Chemical Dependency	Jaw Pain	Swollen Feet/Ankle
Circulation Problems	Kidney Disease	Thyroid Problems
Cortisone Treatments	Liver Disease	Tobacco Habit
Diabetes	Latex Sensitivity	Tonsillitis
Epilepsy	Metal Allergies (e.g:Nickel)	Tuberculosis
Ulcer	Mitral Valve Prolapse	or +PPD Skin Test
Eye Problems	Prolonged Bleeding	Venereal Disease

6. Do you have any disease or condition not listed above? Yes No
   If yes, please describe:_____
7. Please list any medications you are currently taking or have taken within the last six months:
   _____
   _____
   _____
8. Do you have any allergies to any drug or medication? Yes No If yes, please list:
   _____
   _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, the doctor has my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature:_____ Date:_____