

Medical History

Physician _____ Date Of Last Visit ____/____/_____

Please list all medications you are currently taking with dosage:

List all allergies:

Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Indicate which of the following you have had, or have at present? (Check all that apply).

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anxiety Problems | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | |

Other: _____

Please describe any positive responses from the list above:

Do you smoke? Yes No Describe _____

Do you use alcohol? Yes No Describe _____

Do you use recreational drugs? Yes No Describe _____

Have you had surgery or been hospitalized in the last 5 years? Yes No Describe

Dentist's Signature _____ Date: ____/____/_____

History Review _____ History Review _____ History Review _____ History Review _____