MEDICAL HISTORY

Name:____Date:_________

Circle

1. **Are you having pain or discomfort at this time?..Yes No**
2. **Do you feel very nervous about having dentistry treatment?..................... Yes No**
3. **Have you ever had a bad experience in the dentist's office?........................Yes No**
4. **Have you been a patient in the hospital during the past two years?........…Yes No**
5. **Have you been under the care of a medical doctor during the past two years?...Yes No**
6. **List any prescribed or over-the-counter medicines you are presently taking:**
   ____
   ____
7. **Are you allergic to or made sick by penicillin, aspirin, sulfa, codeine, latex , or any other drugs or medications? If so, which ones?....…...……..........Yes No**
8. **Have you ever had any excessive bleeding requiring special treatment?..…Yes No**
9. **Circle any of the following which you have had or have at present:**

Heart Failure
Heart Disease or Attack
Angina Pectoris
High Blood Pressure
Heart Murmur
Mitral Valve Prolapse
Rheumatic Fever
Congenital Heart Lesions
Scarlet Fever
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Anemia
Stroke
Kidney Trouble
Ulcers
Pain in Jaw Joints

Emphysema
Cough
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Hives
Diabetes
Thyroid Disease
X-ray/Cobalt Treatment
Chemotherapy
(Cancer, Leukemia)
Arthritis
Rheumatism
Glaucoma
Cortisone Medicine
Bruise Easily

Depressed Immune System
Hepatitis A (Infectious)
Hepatitis B (Serum)
Liver Disease
Yellow Jaundice
Blood Transfusion
Drug Addiction
Hemophilia
Venereal Disease
Cold Sores
Genital Herpes
Epilepsy or Seizures
Fainting or Dizzy Spells
Psychiatric Treatment
Nervousness
Sickle Cell Disease
Artificial Joint

OVER ...

Circle

10.	**When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired?...**	**Yes No**
11.	**Do your ankles swell during the day?...**	**Yes No**
12.	**Do you use more that two pillows to sleep?..**	**Yes No**
13.	**Have you lost or gained more than ten pounds in the past year?............**	**Yes No**
14.	**Do you ever wake up from sleep short of breath?......................................**	**Yes No**
15.	**Are you on a special diet?...**	**Yes No**
16.	**Has your medical doctor ever said you have cancer or a tumor?...........**	**Yes No**
17.	**Do you have any disease, condition or problem not listed? Please explain...**	**Yes No**
18.	**WOMEN: Are you pregnant?...**	**Yes No**
	Are you practicing birth control?...	**Yes No**
	Do you anticipate becoming pregnant?....................................	**Yes No**

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

____

Signature of Patient, Parent, Guardian

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I authorize release of any information relating to this claim regarding my dental history, treatment, etc. to any insurance company, physician, dentist or organization.

____

Signature Date

Medical History Update

_______ ____

Date Addition

_______ ____

Date Addition