

Medical History

Are you under a physician's care now? Yes _____ No _____

If yes, for what? _____

Are you currently taking any medications? Yes _____ No _____

If yes, what? _____

CHECK any of the following that you have had or have presently:

- | | |
|---|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Dizzy Spells |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Abnormal Blood Pressure HIGH/LOW | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Sinus Troubles |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Chemotherapy: Cancer or Leukemia |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Hepatitis, WHICH _____ | <input type="checkbox"/> X-ray or Cobalt Treatment |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Immune Deficiency Syndrome |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cosmetic Surgery |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Pain in Jaw Joint | <input type="checkbox"/> Joint Replacement, WHICH _____ |
| <input type="checkbox"/> Artificial Prosthesis | |

Other _____

Are you allergic or have you reacted adversely to any of the following:

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Vicoden/Other | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Darvon | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Valium | |

Are you aware of being allergic to any other medications? Yes _____ No _____

If Yes, what? _____

Have you ever had to pre-medicate for a dental visit? Yes _____ No _____

Family Physician _____

May we request your health records if needed? Yes _____ No _____

Are you pregnant at this time? Yes _____ No _____ If yes, how many months _____

Is there any other medical or dental information you feel we should know? _____

This information is given by: _____

SIGNATURE

Date: _____