MEDICAL HISTORY

Patient Name: _____

1. General Health (please check): ○ EXCELLENT ○ GOOD ○ FAIR ○ POOR
2. Name and address of physician: _____
3. Last complete physical: _____
4. Has there been any change in your general health within the past year?.....YES ○ NO ○
5. Are you now under the care of a physician?..... .....YES ○ NO ○
   If so, what is the condition being treated? _____
6. Have you had any serious illness or operation in the past 5 years?.....YES ○ NO ○
   If so, what was the illness or operation? _____
7. Have you been hospitalized for any serious illness within the past five (5) years?.....YES ○ NO ○
   If so, what was the problem? _____
8. Do you use tobacco?.....YES ○ NO ○
   If so, what type and what is your average daily usage? _____
9. Have you had any serious trouble associated with any previous dental treatment?.....YES ○ NO ○
   If so, explain _____

Do you have or have you had any of the following diseases or problems? (Check all that apply)

- ☐ Damaged Heart Valve
- ☐ Artificial Heart Valve
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Congenital Heart Lesion
- ☐ Cardiovascular Disease
- ☐ Heart Attack
- ☐ Angina
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Cardiac Pacemaker
- ☐ Low Blood Pressure
- ☐ Stomach Ulcers
- ☐ Hepatitis
- ☐ Jaundice Or Liver Disease
- ☐ Kidney Problem
- ☐ Allergies
- ☐ Sinus Problem
- ☐ Asthma
- ☐ Hayfever
- ☐ Hives Or Skin Rash
- ☐ Fainting Spells Or Seizures
- ☐ Diabetes
- ☐ Arthritis
- ☐ Inflammatory Rheumatism
- ☐ Hip Or Knee Replacement
- ☐ AIDS Or HIV Positive Test
- ☐ Tuberculosis
- ☐ Persistent Cough
- ☐ Sexually Transmitted Disease
- ☐ Herpes
- ☐ Fever Blisters
- ☐ Abnormal Or Prolonged Bleeding
- ☐ Anemia
- ☐ Cancer Or Tumor
- ☐ Head and Neck Radiation in the Past 3 Years
- ☐ Systemic Steroid Treatment

Women:

1. Are you pregnant?..... YES ○ NO ○
2. Are you nursing?.....YES ○ NO ○
3. Are you taking oral contraceptives?.....YES ○ NO ○

Please list any MEDICATIONS, including over the counter drugs, you currently take:

Medication	Dosage	For what purpose?	Medication	Dosage	For what purpose?

Please list any MEDICATION ALLERGIES and REACTIONS you have had:

Medication	Reaction	Medication	Reaction

Do you have any disease, condition, or problem not listed above that you think I should know about.....YES ○ NO ○
If so, explain _____

To the best of my knowledge the above questions have been accurately answered.

PATIENT NAME (print)_____ PATIENT SIGNATURE_____

DOCTOR'S NOTES

DATE / /

DOCTOR SIGNATURE_____