

MEDICAL HISTORY

PATIENT NAME _____
LAST FIRST MIDDLE

PHYSICIANS NAME _____
ADDRESS/PHONE # _____

DATE OF LAST VISIT _____

LIST CURRENT MEDICATIONS: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES? PLEASE CIRCLE
ASPIRIN PENICILLIN CODEINE LATEX RUBBER ACRYLIC
OTHER: _____

DO YOU NEED PREMEDICATION PRIOR TO A DENTAL VISIT? YES NO
IF YES, WHY? _____

HAVE YOU EVER BEEN HOSPITALIZED? YES NO
IF YES, WHY? _____

HAVE YOU EVER HAD A SERIOUS ILLNESS OR MAJOR INJURY? YES NO
IF YES, WHY? _____

DO YOU SMOKE? YES NO HOW MUCH? _____

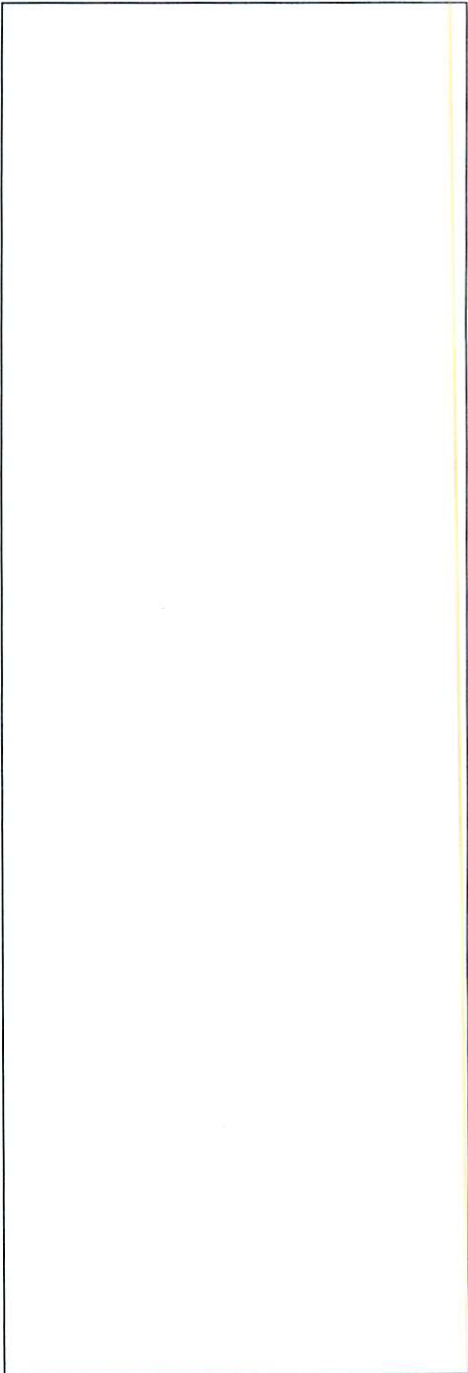
DO YOU WEAR CONTACT LENSES? YES NO

(WOMEN) PLEASE CHECK IF APPROPRIATE: TAKING BIRTH CONTROL PILLS
PREGNANT/TRYING TO GET PREGNANT NURSING

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- | | | |
|-------------------------|--------------------|-----------------------|
| RHEUMATIC FEVER | ASTHMA | ARTIFICIAL JOINT |
| RHEUMATIC HEART DISEASE | DIABETES | SKIN RASH / HIVES |
| HEART MURMUR | FREQUENT URINATION | CORTISONE TREATMENT |
| MITRAL VALVE PROLAPSE | EXCESSIVE THIRST | HIV |
| PROSTHETIC HEART VALVE | HYPOGLYCEMIA | AIDS |
| IRREGULAR HEART BEAT | ANEMIA | GLAUCOMA |
| SHORTNESS OF BREATH | BRUISING | THYROID PROBLEMS |
| CHRONIC TIREDNESS | CANCER | BLOOD TRANSFUSION |
| CHEST PAIN / ANGINA | RADIATION THERAPY | CHEMICAL DEPENDENCY |
| HEART ATTACK | CHEMOTHERAPY | PSYCHIATRIC CARE |
| HIGH BLOOD PRESSURE | TUMOR OR GROWTH | COLD SORES |
| HIGH CHOLESTEROL | STOMACH ULCERS | SICKLE CELL DISEASE |
| STROKE | KIDNEY PROBLEMS | ARTHRITIS |
| SEIZURES / CONVULSIONS | RENAL DIALYSIS | ALLERGIES (MEDICINES) |
| FAINTING / DIZZINESS | TUBERCULOSIS | PARKINSONS DISEASE |
| HEADACHES | PERSISTENT COUGH | DRUG ADDICTION |

OTHER MEDICAL ISSUES NOT CIRCLED ABOVE: _____



SIGNATURE: _____

DATE: _____