PATIENT NAME _____ **DATE** _____

MEDICAL HISTORY

When was your last physical examination? _____

Are you now under the care of a physician? YES NO
If yes, for what medical condition? _____

Have you had a serious illness or operation? YES NO
If yes, please explain _____

Have you been hospitalized within the last year? YES NO
If yes, please explain _____

Are you taking any medication? YES NO
Please list: _____
_____
_____
_____
_____
_____

Do you have an abnormal bleeding tendency? YES NO

Have you had a joint replacement? YES NO
If yes, please explain _____

Do you wish to discuss with the doctor privately any dental or medical problem? YES NO

Are you specifically allergic to (circle all that apply)

Novocain	Penicillin	Sulfa	Other Antibiotics
Aspirin	Codeine	Acrylic	Latex rubber
Other Narcotics	Metal	any over the counter drugs	

List any other drug allergies _____
_____
_____

Have you been treated for Cancer?	YES	NO
Heart Disease?	YES	NO
Drug or Alcohol Addiction?	YES	NO
Bulimia/Anorexia?	YES	NO
Diabetes?	YES	NO
Mental Condition?	YES	NO
Are you HIV positive?	YES	NO
Do you have genital herpes?	YES	NO

FOR WOMEN

Are you pregnant?	YES	NO
Are you taking oral/patch contraceptives?	YES	NO
Are you a nursing mother?	YES	NO

Do you have or have you had any of the following:

	YES NO		YES NO		YES NO		YES NO		YES NO
Heart Abnormalities	___ ___	Bruise Easily	___ ___	Emphysema	___ ___	Hepatitis B (Serum)	___ ___	Cold Sores	___ ___
Heart Murmur	___ ___	Anemia	___ ___	Tuberculosis	___ ___	Yellow Jaundice	___ ___	Fever Blisters	___ ___
Irregular Heart Beat	___ ___	Hemophilia	___ ___	Cancer	___ ___	Kidney Problems	___ ___	Herpes	___ ___
Angina/Chest Pain	___ ___	Sickle Cell Anemia	___ ___	Radiation Therapy	___ ___	Renal Dialysis	___ ___	Stroke or TIA	___ ___
High Cholesterol	___ ___	Swelling of Ankles	___ ___	Chemotherapy	___ ___	Thyroid Disease	___ ___	Convulsions	___ ___
Congenital Heart Disorder	___ ___	Leukemia	___ ___	Stomach Bowel Disease	___ ___	Parathyroid Disease	___ ___	Epilepsy or Seizures	___ ___
Mitral Valve Prolapse	___ ___	Recent Blood Transfusion	___ ___	Ulcers	___ ___	Arthritis/Gout	___ ___	Fainting or Dizziness	___ ___
Scarlet Fever	___ ___	Swelling of Limbs	___ ___	Recent Weight Loss	___ ___	Rheumatism	___ ___	Canker Sores	___ ___
Rheumatic Fever	___ ___	Lung Disease	___ ___	Frequent Diarrhea	___ ___	Painful Joints	___ ___	Tumors or Growths	___ ___
Artificial Heart Valve	___ ___	Breathing Problem	___ ___	Diabetes	___ ___	Cortisone Treatment	___ ___	Nervousness	___ ___
Heart Pace Maker	___ ___	Shortness of Breath	__ ___	Excessive Thirst	___ ___	Liver Disease	___ ___	Psychiatric Care	___ ___
Heart Surgery	___ ___	Frequent Cough	___ ___	Hypoglycemia	___ ___	Venereal Disease	___ ___	Alzheimer's Disease	___ ___
High Blood Pressure	___ ___	Hay Fever	___ ___	Liver Disease	___ ___	AIDS	___ ___	Allergies (Medicines)	___ ___
Low Blood Pressure	___ ___	Use of Inhaler	___ ___	Hepatitis A		HIV Positive	___ ___	Allergies(Pollen/Dust)	___ ___
Blood Disease	___ ___	Asthma	___ ___	(Infectious)	___ ___	Genital Herpes	___ ___	Hives or Rash	___ ___
						Insulin Treatment	___ ___		