Patient Name : **MEDICAL HISTORY**

1. Are you under the care of a physician? ……..... Yes No
   Explain _____
2. Have you ever been hospitalized or had a major operation?..... ..... Yes No
3. Have you ever had a serious head or neck injury?..... Yes No
4. Are you taking any medications, pills or drugs? Please list ……..... Yes No
   …….
5. Do you have any known allergies?..... Yes No
6. Has a physician or previous dentist recommended that you take antibiotics or pre-medication prior to your …. Yes No
   Dental visit? ……Yes No
7. Are you on a special diet? …….. Yes No
8. **Women**, Are you: Pregnant? Nursing? Taking oral contraceptives? …….. Yes No
9. Do you use tobacco?..... Yes No
10. Do you use controlled substances? …… Yes No

Are you **allergic** to any of the following? Please circle
Aspirin Metal Penicillin Latex Codeine Sulfa Drugs Acrylic Local Anesthetic

Indicate which of the following you have had, or have at present. **Circle** each item

AIDS/HIV	Excessive Bleeding	Lung Disease
Alzheimer's Disease	Excessive thirst	Mitral Valve Prolapse
Anemia	Fainting spells or Dizziness	Multiple Sclerosis
Angina	Frequent cough	Nervous Disorder
Arthritis/Rheumatism	Frequent Diarrhea	Neurological Disorder
Artificial Heart Valve	Frequent Headaches	Osteoporosis
Artificial Joints	Genital Herpes	Parathyroid Disease
Asthma	Glaucoma	Psychiatric/Psychological Care
Blood Disease	Hay Fever	Radiation Treatment
Blood Transfusion	Heart Attack/Failure	Renal Disease
Breathing Problems	Heart Murmur	Respiratory Problems
Bruise Easily	Heart Pace maker	Rheumatism
Cancer	Heart Trouble/Disease	Shingles
Chemotherapy	Hemophilia	Sickle Cell Disease
Chest pain	Hepatitis A	Sinus Trouble
Chronic Cough	Hepatitis B or C	Spina Bifida
Cold Sores/Fever Blisters	Herpes	Stomach/Intestinal Disease
Congenital Heart Disease	High Blood Pressure	Stroke
Convulsions	High Cholesterol	Swollen Ankles
Cortisone Medicine.	Hives or rash	Thyroid Problems
Diabetes	Hypoglycemic	Tonsilitis
Drug Addiction	Irregular Heart Beat	Tuberculosis
Easily Winded	Kidney Disease	Tumors
Emphysema	Leukemia	Ulcers
Epinephrine sensitivity	Liver Disease	Venereal Disease
Epilepsy or Seizures.	Low Blood Pressure	Vertigo

Have you ever had any serious illness not listed above?..... Y N

*I certify that I have read and I understand the questions asked. I certify I have answered these questions in completion and **do not** hold the practice, doctor (s), or team responsible for any errors or omission that I have made in completing these forms.*

I consent to the diagnostic procedures and treatment by the dentist (s) of this office necessary for proper dental care.

Patient/Guardian Signature_____ _____Date_____