MEDICAL HISTORY:

1. Yes □ No □ Are you in good health?
2. Yes □ No □ Have you been treated by a Physician during the past 5 years? If yes, what was the condition being treated?
   _____
3. Yes □ No □ Have you ever had any serious illness or operation? If yes, what illness or operation?
   _____
4. Yes □ No □ Have you ever been hospitalized? If yes, what was the problem?
   _____
5. Yes □ No □ Are you sensitive or allergic to (circle): codeine, aspirin, Tylenol, penicillin, Keflex, erythromycin, tetracycline, ibuprofen, latex, acrylic, metal, other?
   _____
6. Yes □ No □ Do you wear a cardiac pacemaker?
7. Yes □ No □ Have you had heart surgery?
8. Yes □ No □ Have you had excessive bleeding requiring special treatment?
9. Yes □ No □ Female Patients: Are you pregnant? If so, what month? _____
10. Yes □ No □ Female Patients: Are you taking birth control medication?
11. Yes □ No □ Have you ever had local anesthetic? (Novocaine, Lidocaine, etc)?
12. Yes □ No □ Have you ever had an unfavorable reaction from local anesthetic?
13. Yes □ No □ Are you presently taking medications? If yes, which?
    _____
14. Yes □ No □ Do you smoke or chew tobacco? If yes, how much? _____
15. Yes □ No □ Do you drink alcohol?

Do you have, or have you had any of the following: (please check one box per item)

Y	N		Y	N		Y	N	
□	□	AIDS/ARC/HIV	□	□	Fibromyalgia	□	□	Night Sweats
□	□	Allergies, Hay Fever	□	□	Glaucoma	□	□	Prosthetic Heart Valve
□	□	Alzheimer's	□	□	Heart Ailments	□	□	Prosthetic Joint(s) _____
□	□	Anemia	□	□	Head Injuries	□	□	Radiation Treatment
□	□	Asthma	□	□	HEPATITIS/JAUNDICE	□	□	Respiratory Disease
□	□	Blood Diseases	□	□	HIGH BLOOD PRESSURE	□	□	RHEUMATIC FEVER
□	□	Cancer, type_____	□	□	HEART MURMUR	□	□	Rheumatism or Arthritis
□	□	Chemo Therapy	□	□	INFECTIVE ENDOCARDITIS	□	□	Sinus Trouble
□	□	Chest Pain (angina)	□	□	Kidney Disease	□	□	Stroke
□	□	Congenital Heart Disease	□	□	Liver Disease	□	□	Stomach Ulcers
□	□	Diabetes	□	□	Medications for osteoporosis	□	□	Thyroid Disease
□	□	Emphysema	□	□	MITRAL VALVE PROLAPSE	□	□	Tumors or Growths
□	□	Epilepsy	□	□	Mental Disorder	□	□	Unexplained weight loss 10+
□	□	Fainting Spells or Seizures	□	□	Nervous Disorder			

DENTAL HISTORY:

Dental complaint at this moment _____

Have you had any serious trouble associated with any previous dental treatment? Yes □ No □ If yes, please explain:

_____

Does dental treatment make you nervous? Yes □ No □ If yes, check: □ slightly a moderately □ extremely

When was your last dental visit? _____ What treatment was done? _____

When was your last set of full mouth x-rays taken? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING – Indicate with a check

- □ Teeth sensitive to cold, heat, pressure
- □ Bleeding gums, how long? _____
- □ Clenching or grinding?
- □ Swelling or lumps in mouth?
- □ Unpleasant taste
- □ Periodontal (gums) treatment
- □ Orthodontic treatment
- □ Herpes/Cold Sores

To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist and her staff of any change in my health and/or medication.

PATIENTS/PARENT'S SIGNATURE _____ DATE _____

REVIEWED BY _____ DATE _____

MEDICAL UPDATES I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT INITIALS	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____