MEDICAL HISTORY

PATIENT NAME:_____ DATE OF BIRTH:__/__/____

1. Are you in pain now? Yes No
2. How long ago did you see a dentist?_____
   Who was your previous dentist?_____
3. Are you now or have you been under a physicians care within the past year? Yes No
   If Yes, specify condition being treated_____
4. Do you take any medications including birth control pills? Specify name and purpose of medication:

_____

_____

5. Do you currently have any of the following:

___ Fainting	___ Heart Disease	___ Heart Murmur	___ Blood Disorder
___ HIV Positive	___Bleed Easily	___ Bruise Easily	___ High Blood Pressure
___ Liver Disease	___ Aids	___ Hepatitis	___Hepatitis C
	___ Depression	___ Anxiety	___ Arthritis

6. Do you require an antibiotic pre-med for a heart condition, artificial valve or artificial joint? Yes No
7. Are you allergic to any local anesthetic? Yes No
8. Have you ever had any severe reaction to dental treatment or local anesthetics? Yes No

9. Have you ever had any of the following:

___ Diabetes	___Rheumatic Fever	___ Asthma	___ Blood Disorder
___Venereal Disease	___ Rheumatism	___ Arthritis	___ Tuberculosis
___ Hepatitis	___ Heart Attack	___ Kidney Disease	___ Immune Disorder
	___ Hepatitis C	___ Liver Disease	___Nervous Breakdown

If so, please specify: _____

10. Have you ever had a reaction or allergic to any of the following:

___ Barbiturates	___ Sulfa Drugs	___ Penicillin	___ Aspirin	___ Codeine
		___ Ibuprofen	___ Tylenol	___ Latex

11. Have you ever had or undergone psychiatric treatment? Yes No
12. Have you ever received counseling for use of alcohol and/or prescription drugs? Yes No
13. Women: Are you pregnant? Yes No
14. Have you ever taken Phen-Fen or similar appetite suppressants? Yes No
    If Yes, have you seen your physician or cardiologist for a cardiac evaluation? Yes No
15. Have you ever used or are you now using tobacco or alcohol? Yes No
16. Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? Yes No

I CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature_____ Date_____

(Patient, legal guardian or authorized agent of patient)