MEDICAL HISTORY

1. Have you been under the care of a physician in the past 2 years? Y N
If yes, please state the reason and the physician who treated you.
Physician Name: _____ **Telephone: { }**_____
Reason:_____
2. Have you been hospitalized in the last 2 years? Y N
If yes, please state the reason: _____
3. Are you currently on any medication? Y N
If yes, please list: _____
4. Are you allergic to any medication or substance? Y N
If yes, please list: _____
5. Have you ever had any excessive bleeding following a dental procedure? Y N
If yes, please state: _____
6. Have you ever been told that you need antibiotics before dental treatment? Y N

7. Please circle any of the following if you have had or presently have:

Heart (Surgery, Disease, Attack)	Yes	No	Asthma	Yes	No
Chest Pain	Yes	No	Hay Fever	Yes	No
Congenital Heart Disease	Yes	No	Latex Sensitivity	Yes	No
Heart Murmur	Yes	No	Allergies or Hive	Yes	No
High Blood Pressure	Yes	No	Sinus Trouble	Yes	No
Mitral Valve Prolapse	Yes	No	Radiation Therapy	Yes	No
Artificial Heart Valve	Yes	No	Chemotherapy	Yes	No
Heart Pacemaker	Yes	No	Tumors	Yes	No
Rheumatic Fever	Yes	No	Hepatitis A{infectious} B{serum}	Yes	No
Arthritis/Rheumatism	Yes	No	Venereal Disease	Yes	No
Cortisone Medicine	Yes	No	A.I.D.S.	Yes	No
Swollen Ankles	Yes	No	H.I.V. Positive	Yes	No
Stroke	Yes	No	Cold Sores/Fever Blisters	Yes	No
Diet (Special/Restricted)	Yes	No	Blood Transfusions	Yes	No
Artificial Joints (hip, knee)	Yes	No	Hemophilia	Yes	No
Kidney Trouble	Yes	No	Sickle Cell Disease	Yes	No
Ulcers	Yes	No	Bruise Easily	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No
Thyroid Problems	Yes	No	Yellow Jaundice	Yes	No
Glaucoma	Yes	No	Neurological Disorders	Yes	No
Contact Lenses	Yes	No	Epilepsy or Seizures	Yes	No
Emphysema	Yes	No	Fainting or Dizzy Spells	Yes	No
Chronic Cough	Yes	No	Nervous/ Anxious	Yes	No
Tuberculosis	*Yes*	*No*	*Psychiatric/Psychological*	*Yes*	*No*

Other conditions not listed above: _____

8. WOMEN: Are you pregnant? Yes No **Are you taking birth control pills?** Yes No

I have answered all questions truthfully and to the best of my knowledge. If further information is required, I grant the dentist permission to secure this from the selected health care provider of agency. Also, I will inform the dentist of any change in my health and/ or medication.

Signature:_____