MEDICAL HISTORY

Please answer **ALL** questions by circling either **YES** or **NO**. If you don't understand a question go on to the next one, the doctor will review it with you. All information is confidential.

1. When did you last receive dental treatment?
   What type of treatment?__________
2. Previous Dentist__________
   City, State__________
3. Do you have dentures, partial dentures or bridges? Y N
4. Date of last physical examination?__________
5. Have you been hospitalized during the past three years? Y N
   If so, please explain.__________
6. Have you had any serious illnesses in the past three years? Y N
   If so, please explain.__________
7. Are you under a physician's care? Y N
   If so, for what condition?__________
   Physician's Name__________
   Phone Number__________

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

CARDIOVASCULAR

8. Rheumatic Fever Y N
9. Congenital Heart Defect Y N
10. Angina or Heart Attack Y N
11. Heart Murmurs Y N
12. Congestive Heart Failure Y N
13. Heart Surgery or Pacemaker Y N
14. High or Low Blood Pressure Y N
15. Stroke Y N

RESPIRATORY DISEASE

16. Asthma or Bronchitis Y N
17. Emphysema Y N
18. Hay Fever or Sinusitis? Y N

ENDOCRINE DISORDERS

19. Diabetes Y N
20. Hyperthyroidism (high thyroid) Y N
21. Hypothyroidism (low thyroid) Y N

BLOOD DISORDERS

22. Anemia Y N
23. Do you bleed excessively when cut? Y N

KIDNEY DISEASE

24. Have you had any kidney infections? Y N
25. Have you had kidney surgery? Y N

INFECTIOUS DISEASES

26. Hepatitus Y N
27. Venereal Disease Y N
28. Tuberculosis Y N
29. HIV Positive Y N

MISCELLANEOUS

30. Frequent Fainting Y N
31. Liver Disease/Jaundice Y N
32. Arthritis Y N
33. Ulcers Y N
34. Glaucoma Y N
35. Radiation Therapy for Cancer Y N
36. Epilepsy Y N
37. Cancer Y N
38. Do you smoke? Y N
39. Do you use any other form of tobacco? Y N
40. Do you have any implanted prosthetic devices? Y N

Are you currently taking any of the following drugs or medications?

41. Antibiotics Y N
42. Blood Thinners Y N
43. Steroids or Cortisone Y N
44. High Blood Pressure Medicine Y N
45. Tranquilizers Y N
46. Immune Suppressant Drugs Y N
47. Aspirin Y N
48. Herbs/Vitamins Y N

Please write down all the prescribed medicines you are now taking: __________

____

____

Do you have an **ALLERGY** or **REACTION** to any of the following medications and materials?

49. Local Anesthetics Y N
50. Penicillin Y N
51. Other Antibiotics Y N
52. Codeine Y N
53. Other Pain Medication Y N
54. Aspirin Y N
55. Barbiturates or Sedatives Y N
56. Nickel Allergy Y N
57. Latex Allergy Y N
58. Other Medicines Y N
    If so, what medicines?__________

59. Have you ever worn braces? Y N
60. Have you ever had gum surgery? Y N
61. Have you ever had any difficulty with any dental work or extractions? Y N
62. Do you have any medical problem not listed above? Y N
    If so, what is it?__________

WOMEN ONLY

63. Are you pregnant? Y N
    If so, when are you due?__________
64. Do you have any menstrual difficulty other than cramps? Y N
65. Are you taking an oral contraceptive? Y N
66. Are you taking hormonal therapy? Y N

____

DOCTOR'S SIGNATURE DATE

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PLEASE SIGN YOUR NAME ON THE LINE ABOVE
(Parents must sign for their minor children)