

Medical History

YES/NO

1. Are you in good health? { } { }
2. Have you had any serious illness or been hospitalized within the past 5 years? { } { }
3. Have you been under the care of a physician in the past 2 years? { } { }
4. Are you subject to prolonged bleeding? { } { }
5. Are you allergic or sensitive to Latex Rubber? { } { }
6. Are you allergic or sensitive to any drugs or medication (such as penicillin, aspirin etc .
If yes, please list: { } { }
7. Have you ever used Phen-Fen? { } { }
If yes, have you consulted your physician? { } { }
8. Do you have or have you had any of the following? (Please answer Yes/No to each of the following).

	Yes/No		Yes/No		Yes/No
Heart Disease or Attack	{ } { }	Hiv Positive	{ } { }	Sinus Trouble	{ } { }
Angina Pectoris	{ } { }	Aids	{ } { }	Respiratory Problem	{ } { }
High Blood Pressure	{ } { }	Hepatitis A	{ } { }	Tuberculosis (TB)	{ } { }
Low Blood Pressure	{ } { }	Hepatitis B	{ } { }	Cortisone Medicine	{ } { }
Heart Murmur	{ } { }	Hepatitis C	{ } { }	Arthritis	{ } { }
Stroke	{ } { }	Veneral Disease	{ } { }	Rheumatic Fever	{ } { }
Mitral Valve Prolapse	{ } { }	Jaundice	{ } { }	Emphysema	{ } { }
Congenital Heart Lesions	{ } { }	Liver Disease	{ } { }	Bruise Easily	{ } { }
Heart Pacemaker	{ } { }	Kidney Disease	{ } { }	Asthma	{ } { }
Anemia	{ } { }	Diabetes	{ } { }	Fever Blisters	{ } { }
Sickle Cell Disease	{ } { }	Glaucoma	{ } { }	Allergies or Hives	{ } { }
Blood Transfusion	{ } { }	Artificial Joints/Pins	{ } { }	Thyroid Disease	{ } { }
Hemophilia	{ } { }	Stomach Troubles/Ulcers	{ } { }	Psychiatric treatment	{ } { }
Leukemia	{ } { }	Epilepsy or Seizures	{ } { }	Hay Fever	{ } { }
Cancer	{ } { }	Fainting or Dizzy Spells	{ } { }	Scarlet Fever	{ } { }
Tumors	{ } { }	Pain in Jaw/Joints	{ } { }	Drug Addiction	{ } { }

Yes/No

9. Have you ever had illness not mentioned above? { } { }
If yes, explain: _____ .
10. Are you taking any medication at this time? { } { }
If yes, explain: _____ .
11. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath or because you are very tired? { } { }
12. Do your ankles swell during the day? { } { }
13. Have you lost or gained more than 10 pounds in the last year? { } { }
14. Do you use more than two pillows to sleep? { } { }
15. Do you ever wake up from sleep short of breath? { } { }
16. Are you on a special diet? { } { }
17. Women Only: Are you pregnant? { } { }
Are you nursing? { } { }
Are you taking oral contraceptives? { } { }

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____