Medical History

Have you been under the care of a medical doctor during the past two years? Yes_____ No_____

Please explain _____

_____

Physician's Name _____ Phone Number_____

Physician's Address_____
Street City/State/Zip Code

Have you ever been hospitalized? Yes_____ No_____ Why_____

Are you allergic to or made sick by? Penicillin _____ Aspirin _____ Codeine _____

Other_____ Please List_____

Have you ever had excessive bleeding requiring special treatment? Yes_____ No_____

Check any of the following which you have had or have at present:

_____Heart Disease or Attack	_____Stroke	_____Allergies or hives
_____Chest Pain	_____Kidney Trouble	_____HIV Positive
_____Tuberculosis (TB)	_____Ulcers	_____Auto Immune Disease
_____Asthma	_____Diabetes	_____Shortness of Breath
_____Rheumatic Fever	_____Emphysema	_____Thyroid Disease
_____Congenital Heart Lesions	_____Common Cold	_____Arthritis
_____Artificial Heart Valve	_____Hepatitis A	_____High Blood Pressure
_____Heart Pacemaker	_____Hepatitis B	_____Heart Murmur
_____Heart Surgery	_____Hepatitis C	_____Hemophilia
_____Artificial Joint	_____Liver Disease	_____Anemia
_____Cold Sores or Fever Blisters	_____ Hay Fever	_____Epilepsy or Seizures

Are you having dental problems at this time? Yes_____ No_____
If yes please explain_____

Do you feel very nervous about having dental treatment? Yes_____ No_____

Do you take pre-medication before dental treatment? Yes _____ No_____
If yes, what do you take?_____

List all medications you are taking at this time_____
_____

Are you a smoker? Yes _____ No_____

Do your ankles swell during the day? Yes_____ No_____

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Medical History (Continued)

Do you have trouble getting numb for dental work? Yes_____ No_____

When you walk up stairs 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? Yes_____ No_____

Women: Are you pregnant? Yes_____ No_____ If yes, when is your due date? _____

Are you taking birth control pills? Yes_____ No_____

Do you have any disease, condition or problem not listed? If so please list_____
_____

How do you feel about getting and maintaining a healthy mouth? _____
_____

How do you feel about the appearance of your teeth?_____

If you could change anything about your smile, what would you change? _____
_____

For office use only

Updates:_____
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