MEDICAL HISTORY

DENTAL HEALTH: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

GENERAL HEALTH: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Name and Address of Physician: ______________________________

Date of Last Complete Physical: ______________________________

Are You Taking Any Medications Now? ❑ Yes ❑ No

For What Purpose? ______________________________

Please List All Medications: ______________________________

Are You Allergic to: ❑ Penicillin ❑ Codeine ❑ Local Anesthetic ❑ Latex ❑ Other: ______________

Do you now have or have you ever had any of the conditions listed below: (**check Yes or No below**)

Condition		Condition	
Abnormal Blood Pressure	❑ Yes ❑ No	HIV Positive / Aids	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Joint Replacement	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	❑ Hip______ Date______ ❑ Knee______ Date______	
Asthma	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No
Bleeding Problems	❑ Yes ❑ No	Prosthetic Heart Valve	❑ Yes ❑ No
Blood Diseases	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Respiratory Problems	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Stroke / TIA's	❑ Yes ❑ No
Epilepsy	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No	Transplant Patient	❑ Yes ❑ No
Heart Disease	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Heart Murmur	❑ Yes ❑ No	Tumors / Biopsies	❑ Yes ❑ No
Hepatitis: ❑ A ❑ B ❑ C	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No

Do you take any of the following medications:

Bisphophonate: ❑ Yes ❑ No Coumadin / Plavix: ❑ Yes ❑ No Daily Asprin: ❑ Yes ❑ No Vitamin E / Fish Oil: ❑ Yes ❑ No

Preferred Local Pharmacy ______________________________

Other Medical Problems Not Listed Above? ______________________________

(Female Only) Are You Currently Pregnant? ❑ Yes ❑ No How Long? ______________ Due Date: __________

Obstetrician's Name: ______________________________

FOR OFFICE USE ONLY

	Initials	Date		Initials	Date		Initials	Date
Review:			**Update:**			**Update:**		
Update:			**Update:**			**Update:**		
Update:			**Update:**			**Update:**		

❑ **MED ALERT:**

Patient Name: ______________________________