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

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

❏ **MED ALERT:**

Patient Name: ______________________________