Patient Medical History

General Health: Good [ ] Fair [ ] Poor [ ]

Physician_____ Office Phone_____ Date of Last Exam_____

Are you currently on any prescription or over the counter medications, vitamins, nutritional or herbal supplements? Yes [ ] No [ ]
if **"Yes"** please list medications and purpose:

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? Yes [ ] No [ ] **if "Yes"** please circle or list

Penicillin Codeine Latex Local Anesthetics Sulfa Drugs Barbiturates Sedatives Iodine Aspirin Any Metals

_____ _____

Please mark the ones that apply to you and your Medical History.

[ ] Need antibiotic coverage prior to dental work?

[ ] Artificial joint replacement or Implant?

[ ] Undergone Radiation or IV Chemotherapy?

[ ] Use or have used tobacco products?

[ ] Subject to prolonged bleeding?

[ ] Family history of Diabetes?

[ ] **Excessive thirst and/or urination?**

[ ] **Recent unusual weight loss?**

[ ] **Subject to fainting?**

[ ] **Recently hospitalized or past major surgeries?**

[ ] **(Women)** Currently pregnant?____ How far?_____

[ ] **(Women)** Currently nursing?____

Please circle Y ***or*** N ***individually for each question:***

Y	N	High or Low Blood Pressure	Y	N	Heart Disease	Y	N	Osteoporosis
Y	N	Heart Attack	Y	N	Cardiac Pace Maker	Y	N	Chest Pains
Y	N	Rheumatic Fever	Y	N	Heart Murmur	Y	N	Long-Term Steroid Treatment
Y	N	Swollen Ankles	Y	N	Artificial Heart Valves	Y	N	Scarlet Fever
Y	N	Fainting / Seizures	Y	N	Frequently Tired	Y	N	Tuberculosis
Y	N	Asthma	Y	N	Anemia	Y	N	Glaucoma
Y	N	Epilepsy / Convulsions	Y	N	Emphysema	Y	N	Liver Disease
Y	N	Leukemia	Y	N	Cancer (type:_____)	Y	N	Hemophilia
Y	N	Diabetes (type:____)(A1C____)	Y	N	Arthritis / Rheumatism	Y	N	Respiratory Problems
Y	N	Kidney Disease	Y	N	Jaundice / Hepatitis (type:____)	Y	N	Mitral Valve Prolapse
Y	N	AIDS / HIV Infection	Y	N	Sexually Transmitted Disease	Y	N	Eating Disorders
Y	N	Thyroid Problem	Y	N	Stomach Troubles / Ulcers	Y	N	Neck or Back Problems

Do you have any other medical or health condition which is not listed? Yes [ ] No [ ] **if "Yes"** please list:

_____

Signature:_____ Date:_____ Staff_____

(For Office Use Only)

Notes & Updates: _____ Updated:_____ Pt..____ Staff_____

_____ Updated:_____ Pt..____ Staff_____

_____ Updated:_____ Pt..____ Staff_____