MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment.
ALL INFORMATION IS CONFIDENTIAL.

		YES	NO
1.	When was the last time you had a medical examination?_____		
2.	Are you presently receiving treatment for any illness?.....	❒	❒
3.	Have you ever been hospitalized?..... Specify:_____	❒	❒
4.	Do you have any heart or circulatory problems? Do you have a pacemaker?..... Specify:_____	❒	❒
5.	Have you ever had rheumatic fever?.....	❒	❒
6.	Do you have any allergies?..... Specify:_____	❒	❒
7.	Are you presently taking any kind of medication? Specify: Drug _____ Reason _____ Drug _____ Reason _____ Drug _____ Reason _____		
8.	Have you ever had a reaction to any kind of medicine?..... Specify:_____	❒	❒
9.	Female patients - Are you pregnant?.....Breastfeeding?.....	❒	❒

10. Do you **presently have** or **have you ever had:**

❒Arthritis	❒Epilepsy/seizures	❒Liver disease (Hepatitis)
❒Asthma	❒Hemorrhage/bleeding	❒Lung disease/chest pains
❒Blood transfusion	❒High/low blood pressure	❒Mental or nervous disorder
❒Cancer/radiotherapy	❒Hyper/hypo glycemia	❒Stroke
❒Congenital heart defect	❒Kidney disease	❒Tuberculosis
❒Diabetes	❒Artificial joints or valves	❒Venereal/communicable disease

11.	Do you smoke?.....	❒	❒
12.	Do you suffer from headaches, earaches or neck aches? (circle if yes)		
13.	Do you grind or clench your teeth?.....	❒	❒

_____ _____

Patient or Guardian Signature **Date**

Update	Comment	Update	Comment