Name _____ Chart # _____

Last First Middle (no initials)

MEDICAL HISTORY

Do You Have, or Have You Ever Had:

YES	NO	
		Heart Disease
		Heart Attack or Stroke
		Heart Murmur
		Heart Arrhythmia
		Heart Surgery
		Chest Pains (Angina)
		Artificial Heart Valve
		Heart Pacemaker/Defibrillator
		Hardening of the Arteries
		High Blood Pressure
		Rheumatic Fever
		Shortness of Breath
		Swelling of the Ankles
		Tire Easily
		Lung Disease
		Emphysema
		Hay Fever or Asthma
		Pneumonia
		Persistent Cough
		Tuberculosis
		Fainting or Dizziness
		Epilepsy or Seizures
		Liver Disease/Jaundice
		Fen-Phen
		Reaction to Dental Anesthetic
		Dental Implants

YES	NO	
		Hepatitis (A, B, C)
		Stomach Disorder/Ulcers
		Unexplained Weight Loss
		Endocrine Disorder
		Diabetes
		Thyroid Disease
		Bone Disorder
		Kidney Disease
		Frequent Urination
		Constant Thirst
		Anemia or Hemophilia
		Bruise Easily
		Sickle Cell Disease
		Blood Transfusion
		Skin Rashes or Hives
		HIV/AIDS/STD's
		Arthritis
		Auto Immune Disease
		Pain in Joints
		Artificial Joint(s)
		Take Aspirin or Blood Thinner
		Prolonged Bleeding
		Facial Pain
		Latex Allergy

YES	NO	
		Enlarged Lymph Glands
		Sinus Problems
		Sore or Hoarse Throat
		Eye Problems/Glaucoma
		Drug/Alcohol Abuse or Addiction
		Psychiatric Treatment
		Cancer or Tumor
		Radiation Therapy
		Chemotherapy
		Prostate Trouble
		Had Orthodontic Braces
		Treatment for Periodontal Disease
		Sore Teeth or Gums
		Sore or Popping Jaw Joints
		Tonsils Removed
		Smoke, How Much_____
		Use Smokeless Tobacco
		Fear Dental Treatment
		Take Vitamins or Herbal Supplements
		Take Premedication Prior to Dental Visits
		Take Anti-Osteoporosis Medication

WOMEN

		Pregnant Now, or Plan on Becoming Pregnant
		Currently Taking any Contraceptives
		Entered Menopause
		Taking Estrogen

What is your present health? Good Fair Poor

Are you ALLERGIC to any medication, drugs, or substance? Specify: _____

Are you now or have you ever been under the care of a physician during the last 2 years? Specify: _____

Do you have or have you ever had any diseases, conditions, or problems not listed above? Specify: _____

Have you ever been hospitalized or had surgery? Specify: _____

Are you presently taking any medication, shots, IV Drugs or over the counter pills? Specify (print): _____

BP _____ _____ _____

Signature Date