

**Medical History**

Physician's Name and Number \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

Have you had any of the following? (Please check any that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Special Diet          |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Hepatitis, Jaundice | <input type="checkbox"/> Rheumatic Fever       |
| <input type="checkbox"/> Anemia/Blood Disorders  | <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Sinus Problems        |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Psychiatric Care    | <input type="checkbox"/> AIDS/HIV              |
| <input type="checkbox"/> Radiation Treatment     | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Thyroid Disease       |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Respiratory Problems    | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Fainting              |
| <input type="checkbox"/> Other Heart Problems    | <input type="checkbox"/> Asthma/Hay Fever    |  |
- Describe \_\_\_\_\_

Have you ever had an allergic reaction to any foods, drugs, latex gloves or metals? If so, please describe \_\_\_\_\_

Have you had any unusual reactions to dental treatment or dental anesthetic? If so, please describe \_\_\_\_\_

Please list any current medications, which you are presently taking \_\_\_\_\_  
\_\_\_\_\_

Are you currently under the care of a physician No \_\_\_ Yes \_\_\_ If so, for what? \_\_\_\_\_  
\_\_\_\_\_

Women – Do you suspect that you are currently pregnant? No \_\_\_ Yes \_\_\_

Are you presently nursing No \_\_\_ Yes \_\_\_

Is there anything else, which we should know about your medical history? \_\_\_\_\_  
\_\_\_\_\_

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date \_\_\_\_\_ Patient Signature \_\_\_\_\_ Doctor/Staff Signature \_\_\_\_\_