Patient Name______________________________ Nickname_______________________ Age__________

Name of Physician____

Date of last physical examination____

What is your estimate of your general health? Poor_________ Fair_________ Good_________

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. Hospitalization for illness or injury………	□	□
2. Allergic reaction to		
□ aspirin, ibuprofen, acetaminophen		
□ penicillin		
□ erythromycin		
□ tetracycline		
□ codeine		
□ local anesthetic		
□ fluoride		
□ metals (gold, stainless steel)		
□ latex		
□ any other medications __________		
3. Heart problems …………………………	□	□
4. Heart murmur……………………………	□	□
5. Rheumatic fever…………………………	□	□
6. Scarlet fever……………………………..	□	□
7. High blood pressure……………………	□	□
8. Stroke…………………………………..	□	□
9. Artificial prosthesis (i.e. heart valve or joints)	□	□
10. Anemia or other blood disorder………	□	□
11. Prolonged bleeding due to a slight cut	□	□
12. Emphysema……………………………	□	□
13. Tuberculosis……………………………	□	□
14. Asthma………………………………..	□	□
15. Sinus problems…………………………	□	□
16. Kidney disease…………………………	□	□
17. Liver disease……………………………	□	□
18. Jaundice………………………………	□	□
19. Thyroid or parathyroid disease……….	□	□
20. Hormone deficiency……………………	□	□
21. High cholesterol………………………..	□	□
22. Diabetes……………………………….	□	□
23. Stomach or duodenal ulcer……………	□	□

	YES	NO
24. digestive disorders…………………….	□	□
25. arthritis…………………………………..	□	□
26. glaucoma………………………………..	□	□
27. contact Lenses………………………….	□	□
28. head or neck injuries…………………..	□	□
29. epilepsy, convulsions (seizures)………	□	□
30. viral infections and cold sores………..	□	□
31. any lumps or swelling in the mouth…..	□	□
32. hives, skin rash, hay fever…………….	□	□
33. venereal disease……………………….	□	□
34. hepatitis (type______)…………………	□	□
35. HIV / AIDS………………………………	□	□
36. tumor, abnormal growth……………….	□	□
37. radiation therapy……………………….	□	□
38. chemotherapy………………………….	□	□
39. emotional problems…………………….	□	□
40. psychiatric treatment…………………..	□	□
41. antidepressant medication…………….	□	□
42. alcohol / drug dependency…………….	□	□
ARE YOU:		
43. presently being treated for any illness..	□	□
44. aware of a change in your general health…	□	□
45. often exhausted or fatigued……………	□	□
46. subject to frequent headaches………..	□	□
47. a heavy smoker (1 pack or more a day)...	□	□
48. considered a touchy person…………....	□	□
49. often unhappy or depressed…………..	□	□
50. easily upset or irritated…………………	□	□
51. FEMALE – taking birth control pills…..	□	□
52. FEMALE – pregnant……………………	□	□
53. MALE – Prostate disorders……………	□	□

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment ____

____

List any medications taken within the last two years_____________________________________

____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Patient's Signature____ Date_________________

Doctor's Ramarks:____

____ Doctor's Signature____________________________