NAME: ______________________ DATE: ______________

Please Circle

1. Are you currently under the care of a physician?........ Yes No
   If yes, for what? ______________________
   Physician's name ______________ Phone ______________
2. Have you ever been hospitalized or had major surgery? .... Yes No
   Please explain ______________________
3. Are you taking any medications? Please list all medications and supplements and reason for use. ....

	Medication	**Reason**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

4. Are you allergic or sensitive to any medications or substances?........ Yes No
   Please explain ______________________
5. WOMEN Are you: Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No
6. Indicate any of the following conditions you have or have had in the past. Please circle "YES" or "NO" for each item.

YES	NO	Heart disease, heart trouble	YES	NO	Diabetes
YES	NO	Artificial heart valve/pacemaker	YES	NO	Asthma
YES	NO	Stroke	YES	NO	Sinus trouble
YES	NO	Heart murmur or rheumatic fever	YES	NO	Osteoporosis
YES	NO	High blood pressure	YES	NO	Hepatitis, jaundice, liver disease
YES	NO	Respiratory problems, emphysema, bronchitis	YES	NO	AIDS or HIV
YES	NO	Stomach ulcer	YES	NO	Thyroid problems
YES	NO	Kidney trouble	YES	NO	Tuberculosis
YES	NO	Sexually transmitted disease	YES	NO	Epilepsy or neurological disease
YES	NO	Problems with mental health	YES	NO	Cancer
YES	NO	Bleeding problems or blood disorder	YES	NO	Radiation treatment
YES	NO	Drug abuse, addiction	YES	NO	Artificial joint (hip, knee, etc.)

Please list any disease, problem or condition not listed above: ______________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature ______________________ Date ______________

Doctor Signature ______________________ Date ______________

MEDICAL HISTORY