Patient Name: _____ **Date of Birth:** ___ / ___ / ___

MEDICAL HISTORY

Have you had, or been diagnosed with any of the following? Please check all those that apply:

AIDS	□ Yes	□ No	If YES, explain: _____
Allergies	□ Yes	□ No	If YES, explain: _____
Anemia	□ Yes	□ No	If YES, explain: _____
Arthritis	□ Yes	□ No	If YES, explain: _____
Artificial Joints	□ Yes	□ No	If YES, explain: _____
Asthma	□ Yes	□ No	If YES, explain: _____
Blood Disease	□ Yes	□ No	If YES, explain: _____
Cancer	□ Yes	□ No	If YES, explain: _____
Diabetes	□ Yes	□ No	If YES, explain: _____
Dizziness	□ Yes	□ No	If YES, explain: _____
Epilepsy	□ Yes	□ No	If YES, explain: _____
Excessive Bleeding	□ Yes	□ No	If YES, explain: _____
Fainting	□ Yes	□ No	If YES, explain: _____
Glaucoma	□ Yes	□ No	If YES, explain: _____
Growths	□ Yes	□ No	If YES, explain: _____
Hay Fever	□ Yes	□ No	If YES, explain: _____
Head Injuries	□ Yes	□ No	If YES, explain: _____
Heart Disease	□ Yes	□ No	If YES, explain: _____
Heart Murmur	□ Yes	□ No	If YES, explain: _____
Hepatitis	□ Yes	□ No	If YES, explain: _____
High Blood Pressure	□ Yes	□ No	If YES, explain: _____
Jaundice	□ Yes	□ No	If YES, explain: _____
Joint Replacement	□ Yes	□ No	If YES, explain: _____
Kidney Disease	□ Yes	□ No	If YES, explain: _____
Liver Disease	□ Yes	□ No	If YES, explain: _____
Mental Disorders	□ Yes	□ No	If YES, explain: _____
Mitral Valve Prolapse	□ Yes	□ No	If YES, explain: _____
Nervous Disorders	□ Yes	□ No	If YES, explain:_____
Pacemaker	□ Yes	□ No	If YES, explain: _____
Pregnancy	□ Yes	□ No	If YES, explain: _____
Radiation Treatment	□ Yes	□ No	If YES, explain:_____
Respiratory Problems	□ Yes	□ No	If YES, explain: _____
Rheumatism	□ Yes	□ No	If YES, explain: _____
Sinus Problems	□ Yes	□ No	If YES, explain: _____
Stent Placement	□ Yes	□ No	If YES, explain: _____
Stomach Problems	□ Yes	□ No	If YES, explain: _____
Stroke	□ Yes	□ No	If YES, explain: _____
Tuberculosis	□ Yes	□ No	If YES, explain: _____
Tumors	□ Yes	□ No	If YES, explain: _____
Ulcers	□ Yes	□ No	If YES, explain: _____
Venereal Disease	□ Yes	□ No	If YES, explain: _____
Other Conditions	□ Yes	□ No	If YES, explain: _____
Other Conditions	□ Yes	□ No	If YES, explain: _____

Novacaine Allergy			
Codeine Allergy	□ Yes	□ No	If YES, explain: _____
Penicillin Allergy	□ Yes	□ No	If YES, explain: _____
Medication Allergy	□ Yes	□ No	If YES, explain: _____
Latex Allergy	□ Yes	□ No	If YES, explain: _____

Patient Name: _____ **Date of Birth:** ___ / ___ / ___

Have you ever been told you need to be pre-medicated prior to dental treatment? ___Yes ___ No
If Yes, for what reason? _____

Have you ever had any complications following dental treatment? ___ Yes ___ No
If Yes, please explain: _____

Have you ever been admitted to a hospital or needed emergency care during the past two (2) years?
___ Yes ___ No
If Yes, please explain: _____

Are you currently under the care of a physician? ___ Yes ___ No
If Yes, please explain: _____

Name of Physician: _____ **Phone #:** _____

Do you have any health problems that need further clarification? ___ Yes ___ No
If Yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information regarding my health are true and accurate. If I ever have a change in my medical history, or any medications I am taking, I will inform the doctors at my next dental appointment, without fail.

_____ _____
Signature of Patient, Parent or Legal Guardian **Date**

Referral Information

Whom may we thank for referring you to our practice? □ Another Patient, Friend □ Another Patient, Relative

□ A Physician □ Dental Office □ Yellow Pages □ School □ Work □ Newspaper □ Other: _____

Name of the person or office that referred you to our practice: _____